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SENATE BILL NO. 1185

Offered January 21, 1999

A BILL to amend and reenact §§ 32.1-137.6, 32.1-137.15, 38.2-3407.10, 38.2-3412.1, 38.2-4209, 38.2-4214, 38.2-4312, 38.2-4319, 38.2-4509 and 38.2-5804 of the Code of Virginia and to amend the Code of Virginia by adding in Title 8.01 a chapter numbered 21.1:01, consisting of a section numbered 8.01-581.20:1; by adding sections numbered 38.2-3407.9:01 and 38.2-3407.11:1; by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.13; by adding in Article 2 of Chapter 34 of Title 38.2 sections numbered 38.2-3418.8 and 38.2-3418.9; and by adding in Title 38.2 a chapter numbered 59, consisting of sections numbered 38.2-5900 through 38.2-5906, and a chapter numbered 60, consisting of sections numbered 38.2-6000 through 38.2-6004, relating to managed care health insurance plans.

Patrons—Walker, Couric, Edwards, Gartlan, Howell, Marsh, Miller, Y.B., Puckett, Reynolds, Ticer and Whipple; Delegates: Almand, Armstrong, Brink, Crittenden, Darner, Day, Deeds, Grayson, Hull, Johnson, Jones, D.C., Jones, J.C., Keating, Moran, Moss, Phillips, Plum, Puller, Robinson, Tate, Thomas, Van Landingham, Van Yahres, Watts, Williams and Woodrum

Referred to Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-137.6, 32.1-137.15, 38.2-3407.10, 38.2-3412.1, 38.2-4209, 38.2-4214, 38.2-4312, 38.2-4319, 38.2-4509 and 38.2-5804 of the Code of Virginia are amended, and that the Code of Virginia is amended by adding by adding in Title 8.01 a chapter numbered 21.1:01, consisting of a section numbered 8.01-581.20:1; by adding sections numbered 38.2-3407.9:01 and 38.2-3407.11:1; by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.13; by adding in Article 2 of Chapter 34 of Title 38.2 sections numbered 38.2-3418.8 and 38.2-3418.9; and by adding in Title 38.2 a chapter numbered 59, consisting of sections numbered 38.2-5900 through 38.2-5906, and a chapter numbered 60, consisting of sections numbered 38.2-6000 through 38.2-6004 as follows:

CHAPTER 21.1:01.

LIABILITY FOR HEALTH TREATMENT DECISIONS BY MANAGED CARE HEALTH INSURANCE PLANS.

§ 8.01-581.20:1. Managed care health insurance plans; liability for health care treatment decisions.

A. For purposes of this section:

"Appropriate and medically necessary" means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community.

"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.

"Health care treatment decision" means a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to a covered person.

"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.

"Ordinary care" means that degree of care that a managed care health insurance plan of reasonable prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, or representative of a managed care health insurance plan, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances.

B. A managed care health insurance plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to a covered person proximately caused by its failure to exercise such ordinary care.

C. A managed care health insurance plan is also liable for damages for harm to a covered person proximately caused by the health care treatment decisions made by its (i) employees, (ii) agents, or (iii) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care.

D. It shall be a defense to any action asserted against a managed care health insurance plan that:

1. Neither the managed care health insurance plan nor any employee, agent, or representative for whose conduct such managed care health insurance plan is liable under subsection C, controlled, influenced, or participated in the health care treatment decision; and

2. The managed care health insurance plan did not deny or delay payment for any treatment prescribed or recommended by a provider to the covered person.

E. The standards in subsections B and C create no obligation on the part of the managed care health insurance plan to provide to a covered person treatment which is not covered by the plan.

F. The provisions of Article 1 (§ 8.01-581.1 et seq.) and Article 2 (§ 8.01-581.13 et seq.) of Chapter 21.1 of this title governing medical malpractice review panels and limiting recovery in certain medical malpractice actions respectively shall not apply to actions brought pursuant to this chapter. In addition, the provisions of Article 1.2 (§ 32.1-137.7 et seq.) and Article 2.1 (§ 32.1-138.6) of Chapter 5 of Title 32.1 governing utilization review standards and appeals and private review agents, respectively, shall not apply to actions brought pursuant to this chapter.

G. The provisions of this chapter are not applicable to any employee welfare benefit plan as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1) which is self-insured or self-funded.

§ 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. *Such forms and written procedures shall include a clear and understandable description of the covered person's right to appeal denials of adverse determinations to the External Appeals Panel described in Chapter 59 (§ 38.2-5900 et seq.) of Title 38.2 and the procedures for making such an appeal.*

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.

§ 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. *If the appeal is denied, such notification shall include a clear and concise notice of the appealing party's right to seek review of the denial by the External Appeals Panel described in Chapter 59 (§ 38.2-5900 et seq.) of Title 38.2 and the procedures for obtaining that review.*

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.

§ 38.2-3407.9:01. Prescription drug formularies.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis; (ii) corporation providing individual or group accident and sickness subscription contracts; and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs on an outpatient basis may apply a formulary to the prescription drug benefits provided by the insurer, corporation, or health maintenance organization if the formulary is developed, reviewed, and updated in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of whose members are licensed physcians.

B. If an insurer, corporation, or health maintenance organization maintains one or more drug formularies, each insurer, corporation or health maintenance organization shall:

1. Disseminate to participating providers and pharmacists the complete drug formulary or formularies maintained by the insurer, corporation, or health maintenance organization, including a list of the prescription drugs on the formulary by major therapeutic category that specifies whether a particular prescription drug is preferred over other drugs; and

2. Establish and maintain an expeditious process or procedure that allows an enrollee to obtain, without penalty or additional cost-sharing beyond that provided for in the individual's covered benefits with the insurer, corporation, or health maintenance organization, coverage for a specific, medically necessary and appropriate nonformulary prescription drug without prior approval from the insurer, corporation, or health maintenance organization.

§ 38.2-3407.10. Health care provider panels.

A. As used in this section:

"Carrier" means:

1. Any insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis;

2. Any corporation providing individual or group accident and sickness subscription contracts;

3. Any health maintenance organization providing health care plans for health care services;

4. Any corporation offering prepaid dental or optometric services plans; or

5. Any other person or organization that provides health benefit plans subject to state regulation, and includes an entity that arranges a provider panel for compensation.

"Enrollee" means any person entitled to health care services from a carrier.

"Provider" means a hospital, physician or any type of provider licensed, certified or authorized by statute to provide a covered service under the health benefit plan.

"Provider panel" means those providers with which a carrier contracts to provide health care services to the carrier's enrollees under the carrier's health benefit plan. However, such term does not include an arrangement between a carrier and providers in which any provider may participate solely on the basis of the provider's contracting with the carrier to provide services at a discounted fee-for-service rate.

B. Any such carrier which offers a provider panel shall establish and use it in accordance with the following requirements:

1. Notice of the development of a provider panel in the Commonwealth or local service area shall be filed with the Department of Health Professions.

2. Carriers shall provide a provider application and the relevant terms and conditions to a provider upon request.

C. A carrier that uses a provider panel shall establish procedures for:

1. Notifying an enrollee of:

a. The termination from the carrier's provider panel of the enrollee's primary care provider who was furnishing health care services to the enrollee; and

b. The right of an enrollee upon request to continue to receive health care services for a period of up to ~~sixty~~ *ninety* days from the date of the primary care provider's notice of termination from a carrier's provider panel, except when a provider is terminated for cause.

2. Notifying a provider at least ~~sixty~~ *ninety* days prior to the date of the termination of the provider, except when a provider is terminated for cause.

3. Providing reasonable notice to primary care providers in the carrier's provider panel of the termination of a specialty referral services provider.

4. Notifying the purchaser of the health benefit plan, whether such purchaser is an individual or an employer providing a health benefit plan, in whole or in part, to its employees and enrollees of the health benefit plan of:

a. A description of all types of payment arrangements that the carrier uses to compensate providers for health care services rendered to enrollees, including, but not limited to, withholds, bonus payments, capitation and fee-for-service discounts; and

b. The terms of the plan in clear and understandable language which reasonably informs the

purchaser of the practical application of such terms in the operation of the plan.

D. Whenever a provider voluntarily terminates his contract with a carrier to provide health care services to the carrier's enrollees under a health benefit plan, he shall furnish reasonable notice of such termination to his patients who are enrollees under such plan.

E. A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of gender, race, age, religion or national origin.

F. 1. For a period of at least ~~sixty~~ *ninety* days from the date of the notice of a provider's termination from the carrier's provider panel, except when a provider is terminated for cause, the provider shall be permitted by the carrier to render health care services to any of the carrier's enrollees who:

a. Were in an active course of treatment from the provider prior to the notice of termination; and

b. Request to continue receiving health care services from the provider.

2. *Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the carrier to continue rendering health services to any enrollee who has entered the second trimester of pregnancy at the time of a provider's termination of participation. Such treatment shall, at the enrollee's option, continue through the provision of post-partum care directly relating to the delivery.*

3. Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the carrier to continue rendering health services to any enrollee who is terminally ill (as defined under § 1861 (dd) (3) (A) of the Social Security Act) at the time of a provider's termination of participation. Such treatment shall, at the enrollee's option, continue for the remainder of the enrollee's life for care directly related to the treatment of the terminal illness.

4. A carrier shall reimburse a provider under this subsection in accordance with the carrier's agreement with the providers.

G. 1. A carrier shall provide to a purchaser prior to enrollment and to existing enrollees at least once a year a list of members in its provider panel, which list shall also indicate those providers who are not currently accepting new patients.

2. The information provided under subdivision 1 shall be updated at least once a year.

H. No contract between a carrier and a provider may require that the provider indemnify the carrier for the carrier's negligence, willful misconduct, or breach of contract, if any.

I. No contract between a carrier and a provider shall require a provider, as a condition of participation on the panel, to waive any right to seek legal redress against the carrier.

J. No contract between a carrier and a provider shall prohibit, impede or interfere in the discussion of medical treatment options between a patient and a provider.

K. A contract between a carrier and a provider shall permit and require the provider to discuss medical treatment options with the patient.

L. *Any carrier requiring preauthorization prior to rendering medical treatment shall have personnel available to provide authorization at all times.*

M. A carrier shall provide to all enrollees and providers written notice of any new benefit restrictions at least ninety days before such restrictions become effective.

N. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

~~M~~*O*. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended on or after July 1, 1996, or at any time after the effective date hereof when any term of any such policy, contract, or plan is changed or any premium adjustment is made. In addition, the requirements of this section shall apply to contracts between carriers and providers that are entered into or renewed on or after July 1, 1996.

P. No contract between a provider and a carrier shall include provisions which include an incentive or specific payment made directly, in any form, to a health care provider or health care provider group as an inducement to deny, reduce, limit or delay specific, medically necessary, and appropriate services provided with respect to a specific enrollee or group of enrollees with similar medical conditions. This subsection does not prohibit the use of capitation as a method of payment.

§ 38.2-3407.11:1. Access to specialists; standing referrals.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services shall permit any individual covered thereunder direct access, as provided in subsection B, to the health care services of a participating specialist (i) authorized to provide services under such policy, contract or plan and (ii) selected by such individual.

B. An insurer, corporation, or health maintenance organization, in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition may receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the

individual's primary and specialty care. If such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to a specialist. For the purposes of this section, "special condition" means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii) requires specialized medical care over a prolonged period of time.

C. Such specialist shall be permitted to treat the individual without a further referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize.

D. An insurer, corporation, or health maintenance organization in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition that requires ongoing care from a specialist may receive a standing referral to such specialist for the treatment of the special condition. If the plan or issuer, or if the primary care provider in consultation with the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to a specialist.

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

F. Each insurer, corporation or health maintenance organization subject to the provisions of this section shall inform subscribers of the provisions of this section. Such notice shall be provided in writing.

G. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, renewed, or extended or at any time when any term of any such policy, contract, or plan is changed or any premium adjustment is made. The provisions of this section shall not apply to short-term travel or accident-only policies, or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-3407.13. Refusal to accept assignments prohibited.

A. No insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, no corporation providing individual or group accident and sickness subscription contracts, no health maintenance organization providing a health care plan for health care services, and no dental services plan offering or administering prepaid dental services shall refuse to accept or make reimbursement pursuant to a bona fide assignment of benefits made to a health care provider or hospital by an insured, subscriber or plan enrollee.

B. For the purpose of this section "assignment of benefits" means the transfer of health care coverage reimbursement benefits or other rights under an insurance policy, subscription contract or health care plan by an insured, subscriber or plan enrollee to a health care provider or hospital.

§ 38.2-3412.1. Coverage for mental health and substance abuse services.

A. As used in this section:

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

"Alcohol or drug rehabilitation facility" means a facility in which a state-approved program for the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State Board of Health pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the State Mental Health, Mental Retardation and Substance Abuse Services Board pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1 or (ii) a state agency or institution.

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

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

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

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

"Mental disorder" means all medically recognized mental illnesses, as defined by the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV), as updated from time to time.

"Mental health services" means treatment for mental, emotional or nervous disorders.

"Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician, clinical psychologist, or a psychologist licensed to practice in this

Commonwealth. The facility shall be (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

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

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

~~"Substance abuse services" means treatment for alcohol or other drug dependence.~~

"Treatment" means services including diagnostic evaluation, medical, psychiatric and psychological care, and psychotherapy for mental~~, emotional or nervous~~ disorders ~~or alcohol or other drug dependence~~ rendered by a hospital, alcohol or drug rehabilitation facility, intermediate care facility, mental health treatment center, a physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed substance abuse treatment practitioner, marriage and family therapist or clinical nurse specialist who renders mental health services. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified ~~alcoholism, drug, or~~ substance abuse counselor employed by a facility or program licensed to provide such treatment *or by a licensed substance abuse treatment professional*.

~~B. Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense-incurred basis for a family member of the insured or the subscriber shall provide coverage for inpatient and partial hospitalization mental health and substance abuse services as follows:~~

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

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

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

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

~~5. This subsection shall not apply to short-term travel, accident only, limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.~~

~~C. Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense-incurred basis for a family member of the insured or the subscriber shall also provide coverage for outpatient mental health and substance abuse services as follows:~~

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

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

~~3. For the purpose of this section, medication management visits shall be covered in the same~~

~~manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of the benefit set forth herein.~~

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

~~5. This subsection shall not apply to short-term travel, accident only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.~~

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

B. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide benefits for inpatient, partial hospitalization, medication management and outpatient treatment of a mental disorder that are not less favorable than benefits for any other illness, condition or disorder that is covered by such policy or contract; however, benefits for treatment of a mental disorder may be different from benefits for other illnesses, conditions or disorders if such benefits meet the medical criteria necessary to achieve the same outcomes as are achieved by the benefits for any other illness, condition or disorder that is covered by such policy or contract.

C. Coverage for mental disorders shall neither be different nor separate from coverage for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

D. Nothing shall preclude the undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of mental disorders under this option, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations made for the treatment of any other illness, condition or disorder covered by such policy or contract.

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

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

§ 38.2-3418.8. Coverage for clinical trials for life-threatening diseases.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for clinical trials for life-threatening diseases under any such policy, contract or plan delivered, issued for delivery, or renewed in this Commonwealth on and after July 1, 1999.

B. The reimbursement for the participation in clinical trials for life-threatening diseases shall be determined according to the same formula by which charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally.

C. For purposes of this section:

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

"FDA" means the Federal Food and Drug Administration.

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

"Multiple project assurance contract" means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal

Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

"NIH" means the National Institutes of Health.

"Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to the member for purposes of a clinical trial. "Patient cost" does not include (i) the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) costs that would not be covered under the patient's policy, plan, or contract for noninvestigational treatments.

D. Coverage for clinical trials for life-threatening diseases shall be provided for participation in a clinical trial as a result of (i) a life-threatening condition or (ii) prevention, early detection, and treatment studies on cancer. Such coverage shall be required if:

1. The treatment is being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or

2. The treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial for any other life-threatening condition. Such treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial for any life-threatening condition other than cancer.

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

1. One of the National Institutes of Health;

2. An NIH cooperative group or an NIH center;

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

4. The Federal Department of Veterans Affairs; or

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

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

G. Coverage under this section shall apply only if:

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

2. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigatonal alternative.

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

§ 38.2-3418.9. Coverage for diabetes.

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

B. Such coverage shall include benefits for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law.

C. To qualify for coverage under this section, diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

D. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category.

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

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

§ 38.2-4209. Preferred provider subscription contracts.

A. As used in this section, a "preferred provider subscription contract" is a contract that specifies how services are to be covered when rendered by providers participating in a plan, by nonparticipating providers, and by preferred providers.

B. Notwithstanding the provisions of §§ 38.2-4218 and 38.2-4221, any nonstock corporation may, as

a feature of its plan, offer preferred provider subscription contracts pursuant to the requirements of this section that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

C. Any such nonstock corporation shall establish terms and conditions that shall be met by a hospital, physician or other type of provider listed in § 38.2-4221 in order to qualify for payment as a preferred provider under the subscription contracts. These terms and conditions shall not discriminate unreasonably against or among health care providers. No hospital, physician or type of provider listed in § 38.2-4221 willing to meet the terms and conditions offered to it or him shall be excluded. Differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with the providers or based on market conditions, or price differences among providers in different geographical areas shall not be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

D. Mandated types of providers listed in § 38.2-4221 and types of providers whose services are required to be made available and which have been specifically contracted for by the holder of any subscription contract shall, to the extent required by § 38.2-4221, have the same opportunity as do doctors of medicine to qualify for payment as preferred providers.

E. Preferred provider subscription contracts shall provide for payment for services rendered by nonpreferred providers, but the payments need not be the same as for preferred providers.

F. No contract between a nonstock corporation and a provider shall include provisions which include an incentive or specific payment made directly, in any form, to a health care provider or health care provider group as an inducement to deny, reduce, limit or delay specific, medically necessary, and appropriate services provided with respect to a specific subscriber or group of subscribers with similar medical conditions. This subsection does not prohibit the use of capitation as a method of payment.

§ 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, 38.2-3407.12~~ *through 38.2-3407.13*, 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, 38.2-3522.1 through 38.2-3523.4, §§ 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3543.2, 38.2-3600 through 38.2-3607, Chapter 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.

§ 38.2-4312. 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, 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.

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.

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.

F. No contract between a health maintenance organization and a provider shall include provisions which include an incentive or specific payment made directly, in any form, to a health care provider or health care provider group as an inducement to deny, reduce, limit or delay specific, medically necessary, and appropriate services provided with respect to a specific enrollee or group of enrollees with similar medical conditions. This subsection does not prohibit the use of capitation as a method of payment.

§ 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, 38.2-203, 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, Articles 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9~~, 38.2-3407.10, 38.2-3407.11, 38.2-3407.12~~ *through 38.2-3407.13*, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1 through ~~38.2-3418.7~~ *38.2-3418.9*, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 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, 38.2-203, 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, *38.2-3407.13*, 38.2-3415, 38.2-3541, 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.

§ 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. . *Such forms and written procedures shall include a clear and understandable description of the covered person's right to appeal denials of adverse determinations to the External Appeals Panel described in Chapter 59 (§ 38.2-5900 et seq.) of Title 38.2 and the procedures for making such an appeal.*

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.

CHAPTER 59.

INDEPENDENT REVIEW OF ADVERSE UTILIZATION REVIEW DECISIONS.

§ 38.2-5900. Application of chapter; definitions.

A. This chapter shall apply to all insurers writing health insurance, all health services plans, and all health maintenance organizations licensed in this Commonwealth.

B. For the purposes of this chapter:

"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 as defined in § 32.1-137.1.

"Utilization review" shall have the same meaning as provided in § 32.1-137.7.

§ 38.2-5901. Appeals to the External Review Panel.

A. After exhausting all complaint and appeal procedures available under Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1, a covered person may appeal an adverse utilization review determination to the External Review Panel pursuant to the procedures set forth in this chapter.

B. To appeal an adverse utilization review determination, a covered person, his authorized representative, or the treating provider with the consent of the covered person shall, within thirty days from receiving a final written determination, file a written appeal with the Bureau of Insurance. The appeal shall be on the forms prescribed by the Bureau of Insurance and shall include a fifty-dollar nonrefundable filing fee. The fee shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400. The Commission may, for good cause shown, waive the filing fee upon a finding that payment of the filing fee will cause undue financial hardship for the covered person. In the event that the covered person prevails as a result of the review of the appeal by the External Appeals Panel as set forth in § 38.2-5902, the filing fee shall be refunded to the covered person.

C. All appeals shall include a general release executed by the covered person for all medical records pertinent to the appeal.

D. Upon receipt of the appeal, the Bureau of Insurance shall, within fifteen days of receipt of all information and documentation necessary, in its sole judgment, for the purposes hereof, conduct a preliminary review of the appeal and accept such appeal if:

1. The individual on whose behalf the appeal was filed was a covered person;

2. The benefit or service that is the subject of the appeal reasonably appears to be a covered service;

3. The covered person has exhausted all complaint and appeals procedures available pursuant to Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1;

4. The covered person has provided all information requested by the Bureau of Insurance necessary to conduct a determination, including (i) the appeal form, (ii) a copy of the final decision of denial, and (iii) a fully executed release to obtain any necessary medical records.

E. Upon completion of the preliminary review, the Bureau of Insurance shall, within five working days, notify the covered person in writing as to whether or not the appeal has been accepted for review, and if not accepted, the reasons therefor.

§ 38.2-5902. Review by External Appeals Panel.

A. Appeals accepted for review in accordance with § 38.2-5901 shall be conducted by a three-member External Appeals Panel appointed pursuant to rules and regulations adopted by the Commission under § 38.2-5903. The External Appeals Panel shall be composed of: (i) a representative from a managed care health insurance plan licensee, as defined in § 32.1-137.1, not involved in the complaint; (ii) an appropriately credentialed health care provider not involved in the complaint; and (iii) the Commissioner of Insurance or the Commissioner's designee.

1. Each plan licensee operating a managed care health insurance plan in the Commonwealth shall, upon request from the Commission, provide and make available the services of its medical director or appropriately qualified employee to serve, without compensation, as a member of an External Appeals Panel as and when requested by the Commission.

2. The Board of Medicine shall be required, when requested by the Commission, to furnish the Commission with a list of appropriately qualified and credentialed licensed health care practitioners willing and able to serve, without compensation, as members of External Appeals Panels as and when requested by the Commission. Such list of practitioners shall encompass, to the extent possible, all known areas of medical specialization that might be needed for purposes of reviewing appeals as set forth herein.

3. Upon receipt of an appeal that has been accepted for review pursuant to § 38.2-5901, the Commission shall select from among those so designated one representative from a licensee operating a managed care health insurance plan in the Commonwealth to serve as a member of the External Appeals Panel. The Commission shall also select, from the list provided by the Board of Medicine, three health care practitioners who appear reasonably qualified to review the substance of the appeal, and shall furnish those names to the individual who submitted the appeal. The individual who submitted the appeal shall, within ten working days of receipt of the three names, and after consultation with the individual's treating physician if desired, select one of the three health care practitioners to serve as a member of the External Appeals Panel and so inform the Commission. If the individual fails to select a practitioner to serve on the External Appeals Panel within ten days, the individual may lose any appeal rights under this chapter, unless there is good cause shown for the delay.

4. The Commission shall, within five working days thereafter: (i) inform the members of the External Appeals Panel of their selection; (ii) provide each member with copies of all documents, records, and other information necessary for review of the appeal; (iii) inform the individual who submitted the appeal and the managed care health insurance plan licensee whose adverse decision is the subject of the appeal of the names of the members of the External Appeals Panel; and (iv) provide an opportunity for the individual who submitted the appeal and the managed care health insurance plan licensee whose adverse decision is the subject of the appeal to submit in writing, within ten days of receipt of such notice and in a form and manner prescribed by the Commission, any additional information that the individual or managed care health insurance plan licensee believes would assist the External Appeals Panel in its review.

B. Within thirty days after the composition of the External Appeals Panel for the specific appeal has been determined, each member of the External Appeals Panel shall be provided with all documentation relevant to the appeal. The External Appeals Panel shall have the right to request such additional information to be provided by the parties as the External Appeals Panel, in its sole judgment, deems necessary to reach a decision, including but not limited to the following: (i) pertinent medical records; (ii) consulting physician reports; (iii) practice guidelines developed by the federal government, national, state or local medical societies, boards, or associations; and (iv) clinical protocols or practice guidelines developed by the utilization review organization or managed care health insurance plan whose decision is the basis for the appeal.

C. The External Appeals Panel shall review all such documentation and shall meet in person or by other means of communication, to discuss the appeal and reach a decision. The work of the External Appeals Panel shall be conducted in the form of document review, and nothing herein shall be construed to provide any party to the appeal with the right to an informal or formal hearing before the External Appeals Panel. The decision of the External Appeals Panel shall be rendered within ninety days of the composition of the External Appeals Panel. The decision of the External Appeals Panel shall be made by a simple majority vote of the three-member External Appeals Panel.

D. The External Appeals Panel shall communicate its decision to the parties to the appeal within five

working days. If the decision of the External Appeals Panel is in favor of the covered person, the managed care health insurance plan licensee shall provide coverage without delay for the subject health care service. Nothing herein shall be construed to deny either party a private right of action in a court of competent jurisdiction, except that such private right of action on behalf of the managed care health insurance plan licensee shall be limited to matters other than the necessity, appropriateness and efficiency of subject health care services. The decision of the External Appeals Panel shall be admissible in any proceeding, but not dispositive. The decision of the External Appeals Panel shall not be appealable to, or subject to review by, the Commission.

E. There shall be no liability on the part of and no cause of action shall arise against any member of an External Appeals Panel for any actions taken or not taken or statements made by such member in good faith in the performance of their powers and duties.

F. Any managed care health insurance plan licensee that is required to provide previously denied services as a result of the review by the External Appeals Panel shall be subject to payment of such fees as the Commission shall deem appropriate to cover the costs of the review.

§ 38.2-5903. Rules and regulations.

Pursuant to the authority granted by § 38.2-223, the Commission promulgate such rules and regulations as it may deem necessary to implement this chapter. Such regulations may include provisions for expedited consideration of appeals in cases involving emergency health care.

§ 38.2-5904. Assessment to fund appeals.

A. Each licensed insurer, health maintenance organization, and health services plan doing business in the Commonwealth by writing any type of insurance as defined in § 38.2-109 shall pay, in addition to any other assessments provided in this title, an assessment in an amount not to exceed 0.01 percent of the direct gross premium income during the preceding calendar year. The assessment shall be apportioned and assessed and paid as prescribed by § 38.2-403.

B. The assessment shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

§ 38.2-5905. Penalties.

In addition to any other penalties provided for violations of this title, managed care health insurance plan licensees that do not comply, within ten working days after receipt of notification, with the decisions reached by the External Appeals Panel following its review as set forth in § 38.2-5902 shall be deemed to have violated this chapter and shall be subject to an additional penalty of $500 per day for each subsequent day of noncompliance with the decision of the External Appeals Panel.

§ 38.2-5906. Effective date.

This chapter shall take effect on July 1, 1999; however, the appeal processes set forth in this chapter shall not take effect until the earlier of (i) ninety days following the promulgation of regulations by the Commission as set forth in § 38.2-5903 or (ii) July 1, 2000.

CHAPTER 60.

OFFICE OF THE STATE MANAGED CARE CONSUMER ADVOCATE.

§ 38.2-6000. Office of the State Managed Care Consumer Advocate established.

A. The Commissioner of Insurance shall establish the Office of the State Managed Care Consumer Advocate by contract with any nonprofit organization.

B. The Office of the State Managed Care Consumer Advocate shall:

1. Assist health insurance consumers with health insurance plan selection by providing information, referral and assistance to individuals about means of obtaining health insurance coverage and services;

2. Assist health insurance consumers to understand their rights and responsibilities under health insurance plans;

3. Provide information to the public, agencies, legislators and others regarding problems and concerns of health insurance consumers and make recommendations for resolving those problems and concerns;

4. Identify, investigate and resolve complaints on behalf of individual health insurance consumers (including complaints of denial of care or discriminatory treatment or service on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment), and assist those consumers with the filing and pursuit of complaints and appeals;

5. Analyze and monitor the development and implementation of federal, state and local laws, regulations and policies relating to health insurance consumers, and recommend changes it deems necessary;

6. Facilitate public comment on laws, regulations and policies, including policies and actions of health insurers;

7. Ensure that health insurance consumers have timely access to the services provided by the office;

8. Coordinate with other entities which provide information and advocacy for Virginia health care

consumers;

9. Submit to the General Assembly and to the Governor on or before January 1 of each year a report on the activities, performances and fiscal accounts of the office during the preceding year.

C. The Office of the State Managed Care Consumer Advocate may:

1. Hire or contract with persons to fulfill the purposes of this chapter;

2. Review the health insurance records of a consumer who has provided written consent. Based on the written consent of the consumer or the consumer's guardian or legal representative, a health insurer shall provide the State Managed Care Consumer Advocate access to records relating to that consumer;

3. Pursue administrative, judicial and other remedies on behalf of any individual health insurance consumer or group of consumers;

4. Delegate to employees and contractors of the consumer advocate any part of the state consumer advocate's authority;

5. Adopt policies and procedures necessary to carry out the provisions of this chapter;

6. Take any other actions necessary to fulfill the purposes of this chapter.

D. All state agencies shall comply with reasonable requests from the Office of the State Managed Care Consumer Advocate for information and assistance. The Commissioner of Insurance may adopt rules necessary to assure the cooperation of state agencies under this subsection.

E. In the absence of written consent by a complainant or an individual utilizing the services of the Office, or his or her guardian or legal representative, or court order, the Office of the State Managed Care Consumer Advocate, its employees and contractors, shall not disclose the identity of the complainant or individual.

§ 38.2-6001. Conflicts of interest.

The Office of the State Managed Care Consumer Advocate, and its employees and contractors, shall not have any conflict of interest relating to the performance of their responsibilities under this chapter. For the purposes of this section, a conflict of interest exists whenever the Office of the State Managed Care Consumer Advocate, its employees or contractors, or a person affiliated with the Office of the State Managed Care Consumer Advocate, or its employees and contractors;

1. Have direct involvement in the licensing, certification, or accreditation of a health care facility, health insurer, or a health care provider;

2. Have direct ownership interest or investment interest in a health care facility, health insurer, or a health care provider;

3. Are employed by, or participating in the management of a health care facility, health insurer, or a heath care provider; or

4. Receive or have the right to receive, directly or indirectly, remuneration under a compensation arrangement with a health care facility, health insurer or health care provider.

§ 38.2-6002. Advocacy; annual reports.

A. The Office of the State Managed Care Consumer Advocate shall be able to speak on behalf of the interests of health care and health insurance consumers and to carry out all duties prescribed in this chapter without being subject to any disciplinary or retaliatory action. Nothing in this subsection shall limit the authority of personnel or other action.

B. The Office of the State Managed Care Consumer Advocate shall report to the Joint Commission on Health Care on or before December 1 of each year. The report shall provide the Commission with an update on the status of implementation of the Office of the State Managed Care Consumer Advocate program, together with a description of the manner in which the Office of the State Managed Care Consumer Advocate is, and will in the future, be coordinating its activities with other existing health care information and advocacy programs within the Commonwealth.

§ 38.2-6003. Funding.

A. The Office of the State Managed Care Consumer Advocate shall be funded through an annual assessment of up to 0.01 percent of the net direct premiums of insurers, health services plans and health maintenance organizations licensed pursuant to Chapters 34 (§ 38.2-3400, et seq.), 42 (§ 38.2-4200 et seq.), and 43 (§ 38.2-4300, et seq.) of this title, as reported to the Virginia State Corporation Commission.

B. For purposes of this section "net direct premiums" means gross direct premiums written in this Commonwealth by such insurers, health services plans and health maintenance organizations, less (i) all return premiums, (ii) dividends paid or credited, and (iii) the unused or unabsorbed portions of premium deposits.

C. All assessments collected by the Virginia State Corporation Commission pursuant to this section shall be transferred to a special fund known as the "State Managed Care Consumer Advocate Fund" established herewith, which fund shall be administered by the State Insurance Commissioner and utilized to fund the operations of the Office of the State Managed Care Consumer Advocate.

§ 38.2-6004. State Managed Care Consumer Advocate Fund established.

A. There is hereby established a special, nonreverting fund in the state treasury to be known as the State Managed Care Consumer Advocate Fund, hereafter referred to as the Fund, to be used for operations of the Office of the State Managed Care Consumer Advocate as provided in this chapter.

B. The Fund shall be a nonlapsing fund consisting of moneys from the assessments provided in § 38.2-6003. Interest earned on the Fund shall be credited to the Fund. The Fund shall be established on the books of the State Comptroller. Any money remaining in the Fund at the end of the biennium shall not revert to the general fund but shall remain in the Fund.

C. Disbursement of moneys from the Fund shall be made by the Commissioner of Insurance for the purposes set forth in this chapter.