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SENATE BILL NO. 1185

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Finance
on February 4, 1999)

(Patron Prior to Substitute—Senator Walker)

A BILL to amend and reenact §§ 32.1-137.6, 32.1-137.15, 38.2-3407.10, 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 a section numbered 38.2-3418.8; and by adding in Title 38.2 a chapter numbered 59, consisting of sections numbered 38.2-5900 through 38.2-5904, and a chapter numbered 60, consisting of sections numbered 38.2-6000 through 38.2-6003, relating to managed care health insurance plans.

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-137.6, 32.1-137.15, 38.2-3407.10, 38.2-4209, 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 a section numbered 38.2-3418.8; and by adding in Title 38.2 a chapter numbered 59, consisting of sections numbered 38.2-5900 through 38.2-5904, and a chapter numbered 60, consisting of sections numbered 38.2-6000 through 38.2-6003 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.

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

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

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

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

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

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

76 *F. The provisions of Article 1 (§ 8.01-581.1 et seq.) and Article 2 (§ 8.01-581.13 et seq.) of Chapter*
77 *21.1 of this title governing medical malpractice review panels and limiting recovery in certain medical*
78 *malpractice actions respectively shall not apply to actions brought pursuant to this chapter. In addition,*
79 *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*
80 *32.1 governing utilization review standards and appeals and private review agents, respectively, shall*
81 *not apply to actions brought pursuant to this chapter.*

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

85 *§ 32.1-137.6. Complaint system.*

86 *A. Each managed care health insurance plan licensee subject to § 32.1-137.2 shall establish and*
87 *maintain for each of its managed care health insurance plans a complaint system approved by the*
88 *Commissioner and the Bureau of Insurance to provide reasonable procedures for the resolution of*
89 *written complaints in accordance with the requirements established under this article and Title 38.2, and*
90 *shall include the following:*

91 *1. A record of the complaints shall be maintained for the period set forth in § 32.1-137.16 for review*
92 *by the Commissioner.*

93 *2. Each managed care health insurance plan licensee shall provide complaint forms and/or written*
94 *procedures to be given to covered persons who wish to register written complaints. Such forms or*
95 *procedures shall include the address and telephone number to which complaints shall be directed and*
96 *shall also specify any required limits imposed by or on behalf of the managed care health insurance*
97 *plan. Such forms and written procedures shall include a clear and understandable description of the*
98 *covered person's right to appeal denials of adverse determinations to the External Appeals Panel*
99 *described in Chapter 59 (§ 38.2-5900 et seq.) of Title 38.2 and the procedures for making such an*
100 *appeal. A written waiver acknowledging the final and binding nature of such an appeal shall also*
101 *accompany such forms and procedures.*

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

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

117 *The Department of Personnel and Training and the Department of Medical Assistance Services shall*
118 *file similar periodic reports with the Commissioner, in a form prescribed by the Board, providing*
119 *appropriate information on all complaints received concerning quality of care and utilization review*
120 *under their respective health benefits program and managed care health insurance plan licensee*
121 *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, the procedures for obtaining that review, and the binding nature and effect of such an appeal.*

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 Article 2.1 of Chapter 5 (§ 32.1-1328.6 et seq.), shall terminate the employment or other contractual relationship or otherwise penalize a health care provider for advocating the interest of his patient or patients in the appeals process or invoking the appeals process, unless the provider engages in a pattern of filing appeals that are without merit.

§ 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

183 maintenance organization providing a health care plan for health care services, whose policy, contract
184 or plan, including any certificate or evidence of coverage issued in connection with such policy, contract
185 or plan, includes coverage for prescription drugs on an outpatient basis may apply a formulary to the
186 prescription drug benefits provided by the insurer, corporation, or health maintenance organization if
187 the formulary is developed, reviewed, and updated in consultation with and with the approval of a
188 pharmacy and therapeutics committee, a majority of whose members are licensed physicians.

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

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

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

200 § 38.2-3407.10. Health care provider panels.

201 A. As used in this section:

202 "Carrier" means:

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

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

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

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

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

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

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

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

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

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

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

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

224 1. Notifying an enrollee of:

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

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

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

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

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

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

240 b. The terms of the plan in clear and understandable language which reasonably informs the
241 purchaser of the practical application of such terms in the operation of the plan.

242 D. Whenever a provider voluntarily terminates his contract with a carrier to provide health care
243 services to the carrier's enrollees under a health benefit plan, he shall furnish reasonable notice of such
244 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, except when a provider is terminated for cause. 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, except when a provider is terminated for cause. 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 such preauthorization 24-hours a day, seven days a week. Such personnel shall be available via toll-free telephone, and shall have the authority to provide the preauthorization.*

M. *A group policyholder shall provide to all enrollees written notice of any benefit reductions during the contract period at least sixty days before such benefit reductions become effective.*

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

MO. 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. *However, the ninety day period referred to in C 1 b and C 2 of this section shall apply to contracts between carriers and providers that are entered into or renewed after July 1, 1999, and the requirements set forth in F 2, F 3, and M shall apply to contracts between carriers and providers that are entered into or renewed on or after July 1, 1999.*

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 related to the initial specialty care referral. 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. Within the treatment period authorized by the referral, 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, to short-term nonrenewable policies of not more than six months' duration, or policies or contracts issued to persons eligible under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 38.2-3407.13. 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.

§ 38.2-3418.8. 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 in the same manner as reimbursement is determined for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments, and coinsurance factors that are no less favorable than for physical illness generally.

C. For purposes of this section:

"Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. "Cooperative group" includes (i) the National Cancer Institute Clinical Cooperative group, (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, or (ii) costs associated with managing the research associated with the clinical trial.

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, or treatment studies on cancer. Such coverage shall be required if the treatment is being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer or 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.

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 noninvestigational alternative.

H. The provisions of this section shall not apply to short-term travel, accident-only, 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.

§ 38.2-4209. 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

429 *appropriate services provided with respect to a specific subscriber or group of subscribers with similar*
430 *medical conditions. This subsection does not prohibit the use of capitation as a method of payment.*

431 § 38.2-4214. Application of certain provisions of law.

432 No provision of this title except this chapter and, insofar as they are not inconsistent with this
433 chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230,
434 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
435 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,
436 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2
437 (§ 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,
438 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401,
439 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,~~
440 ~~38.2-3407.11, 38.2-3407.12~~ through 38.2-3407.13, 38.2-3409, 38.2-3411 through 38.2-3419.1,
441 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
442 38.2-3520 as they apply to Medicare supplement policies, 38.2-3522.1 through 38.2-3523.4,
443 §§ 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
444 (§ 38.2-5300 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) of this title shall apply to the operation of a
445 plan.

446 § 38.2-4312. Prohibited practices.

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

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

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

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

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

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

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

476 E. No health maintenance organization shall unreasonably discriminate against physicians as a class
477 or any class of providers listed in § 38.2-4221 or pharmacists when contracting for specialty or referral
478 practitioners or providers, provided the plan covers services which the members of such classes are
479 licensed to render. Nothing contained in this section shall prevent a health maintenance organization
480 from selecting, in the judgment of the health maintenance organization, the numbers of providers
481 necessary to render the services offered by the health maintenance organization.

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

488 § 38.2-4319. Statutory construction and relationship to other laws.

489 A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this
490 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, 38.2-3418.8, 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

552 filed, (v) the time it took to process and resolve each complaint, and (vi) the number, amount, and
553 disposition of malpractice claims adjudicated during the year with respect to any of the MCHIP's
554 affiliated providers.

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

559 § 38.2-5804. Complaint system.

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

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

565 2. Such health carrier shall provide complaint forms and/or written procedures to be given to covered
566 persons who wish to register written complaints. Such forms or procedures shall include the address and
567 telephone number to which complaints shall be directed and shall also specify any required limits
568 imposed by or on behalf of the MCHIP. *Such forms and written procedures shall include a clear and*
569 *understandable description of the covered person's right to appeal final adverse decisions to the Bureau*
570 *of Insurance in accordance with Chapter 59 (§ 38.2-5900 et seq.), the procedures for making such an*
571 *appeal, and the binding nature and effect of such an appeal.*

572 B. The Commission, in cooperation with the State Health Commissioner, shall examine the complaint
573 system. The effectiveness of the complaint system of the managed care health insurance plan licensee in
574 allowing covered persons, or their duly authorized representatives, to have issues regarding quality of
575 care appropriately resolved under this chapter shall be assessed by the State Health Commissioner
576 pursuant to provisions in Title 32.1 and the regulations promulgated thereunder. Compliance by the
577 health carrier and its managed care health insurance plans with the terms and procedures of the
578 complaint system, as well as the provisions of this title, shall be assessed by the Commission.

579 C. The health carrier for each MCHIP shall submit to the Commission and the State Health
580 Commissioner an annual complaint report in a form prescribed by the Commission and the Board of
581 Health. The complaint report shall include (i) a description of the procedures of the complaint system,
582 (ii) the total number of complaints handled through the grievance or complaint system, (iii) the
583 disposition of the complaints, (iv) a compilation of the nature and causes underlying the complaints
584 filed, (v) the time it took to process and resolve each complaint, and (vi) the number, amount, and
585 disposition of malpractice claims adjudicated during the year with respect to any of the MCHIP's
586 affiliated providers.

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

591 CHAPTER 59.

592 INDEPENDENT EXTERNAL REVIEW OF ADVERSE UTILIZATION REVIEW DECISIONS.

593 § 38.2-5900. Application of chapter; definitions.

594 *This chapter shall apply to all utilization review entities established pursuant to Article 1.2*
595 *(§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1. The definitions in § 32.1-137.7 shall have the same*
596 *meanings ascribed to them in § 32.1-137.7 when used in this chapter.*

597 § 38.2-5901. Review by the Bureau of Insurance.

598 A. A covered person or a treating health care provider, with the consent of the covered person, may
599 in accordance with this section appeal to the Bureau of Insurance for review of any final adverse
600 decision concerning a health service costing more than \$500. The appeal shall be filed within thirty
601 days of the final adverse decision, shall be in writing on forms prescribed by the Bureau of Insurance,
602 shall include a general release for all medical records pertinent to the appeal executed by the covered
603 person, and shall be accompanied by a fifty-dollar nonrefundable filing fee. The fee shall be collected
604 by the Commission and paid directly into the state treasury and credited to the fund for the maintenance
605 of the Bureau of Insurance as provided in subsection B of § 38.2-400. The Commission may, for good
606 cause shown, waive the filing fee upon a finding that payment of the filing fee will cause undue
607 financial hardship for the covered person. The applicant shall provide a copy of the written appeal to
608 the utilization review entity which made the final adverse decision.

609 B. The Bureau of Insurance or its designee shall conduct a preliminary review of the appeal to
610 determine (i) whether the applicant is a covered person or a treating health care provider with the
611 consent of the covered person, (ii) whether the benefit or service that is the subject of the application
612 reasonably appears to be a covered service costing more than \$500, (iii) whether all complaint and
613 appeal procedures available under Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 have

been exhausted, and (iv) whether the application is otherwise complete and filed in compliance with this section. The Bureau of Insurance shall not accept for review any application which fails to meet the criteria set forth in this subsection. Within five working days of completion of the preliminary review, the Bureau of Insurance or its designee shall notify the applicant and the utilization review entity in writing whether the appeal has been accepted for review, and if not accepted, the reasons therefor.

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

§ 38.2-5902. Appeals; impartial health entity.

A. The Bureau of Insurance shall contract with impartial health entities for the purpose of performing the review of final adverse decisions. The physician of the reviewing entity shall have at least the same education and training as the treating health care provider. The impartial health entity shall examine the final adverse decision to determine whether the decision is objective, clinically valid, compatible with established principles of health care, and appropriate in light of the contractual obligations of the utilization review entity. The impartial health entity shall review the written appeal; the response of the utilization review entity; any affidavits which either the covered person, the treating health care provider, or the utilization review entity may file with the Bureau of Insurance; and such medical records as the impartial health entity shall deem appropriate. The impartial health entity shall issue its written recommendation affirming, modifying or reversing the final adverse decision within sixty days of the acceptance of the appeal by the Bureau of Insurance. The Commission, based upon such recommendation, shall issue a written order affirming, modifying or reversing the final adverse decision within five working days of the recommendation of the impartial health entity. The Commission's order shall carry out the recommendations of the impartial health entity unless the impartial health entity exceeded its authority, acted arbitrarily or capriciously, or abused its discretion. The order of the Commission shall bind the covered person and the utilization review entity to the extent to which each would have been obligated by a judgment entered in an action at law with respect to the final adverse decision.

B. Impartial health entities may include medical peer review organizations, independent utilization review companies, or other health care entities which the Commission, by regulation, shall determine to possess the necessary credentials and otherwise to be qualified to perform such review. The Commission shall approve impartial health entities in advance of any appeal; provided, that the impartial health entity conducting the review of a final adverse decision shall have no relationship or association with (i) the utilization review entity, or any officer, director or manager of such utilization review entity, (ii) the covered person, (iii) the treating health care provider, or any of its employees or affiliates, (iv) the medical care facility at which the covered service would be provided, or any of its employees or affiliates, or (v) the development or manufacture of the drug, device, procedure or other therapy which is the subject of the final adverse decision.

§ 38.2-5903. 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. Such assessment shall be based upon the anticipated costs attributable to implementation of the review of final adverse decisions by the Bureau of Insurance pursuant to this chapter, adjusted for actual receipts and expenditures in the prior fiscal 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.

§ 38.2-5904. Rules and regulations.

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

CHAPTER 60.

OFFICE OF THE STATE MANAGED CARE CONSUMER ADVOCATE.

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

A. An Office of the State Managed Care Consumer Advocate (the "Office") is hereby created within

675 the Division of Consumer Counsel in the Office of the Attorney General. The Office shall be headed by
676 a Managed Care Consumer Advocate to be appointed by the Attorney General.

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

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

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

682 3. Provide information to the public, agencies, legislators and others regarding problems and
683 concerns of health insurance consumers;

684 4. Assist individual health care consumers in identifying available procedures for resolution of
685 disputes concerning their health care plans and in initiating such dispute resolution procedures;

686 5. Analyze and monitor the development and implementation of federal, state and local laws,
687 regulations and policies relating to health insurance consumers;

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

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

691 8. Coordinate with other entities that provide information and advocacy for Virginia health care
692 consumers;

693 9. Develop and maintain a system and program of data collection to assess the impact of benefits
694 and providers, including costs to employers and insurers, impact of treatment, cost savings in the health
695 care system, number of providers, and other similar data on managed care health insurance plans
696 which the Managed Care Consumer Advocate deems appropriate;

697 10. Provide assessments of proposed and existing managed care health insurance laws and other
698 studies of managed care health insurance plan issues upon request by either of the joint standing
699 committees of the General Assembly having jurisdiction over insurance;

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

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

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

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

707 3. Pursue administrative, judicial and other remedies on behalf of health insurance consumers;

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

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

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

712 D. All state agencies shall comply with reasonable requests from the Office of the State Managed
713 Care Consumer Advocate for information and assistance. The Attorney General may adopt rules
714 necessary to facilitate the cooperation of state agencies under this subsection.

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

719 § 38.2-6001. Conflicts of interest.

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

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

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

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

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

733 § 38.2-6002. Advocacy; annual reports.

734 A. The Office of the State Managed Care Consumer Advocate shall be able to speak on behalf of the
735 interests of health care and health insurance consumers and to carry out all duties prescribed in this
736 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.

Each licensed insurer writing insurance as defined in § 38.2-109, each health maintenance organization organized in accordance with provisions in Chapter 43 (§ 38.2-4300 et seq.) and each nonstock corporation organized in accordance with provisions in Chapter 42 (§ 38.2-4200 et seq.) or Chapter 45 (§ 38.2-4500 et seq.) shall pay, in addition to any other assessments provided in this title, an assessment in an amount not to exceed 0.012 percent of the direct gross premium income for such insurance written during the preceding calendar year. The Fund shall not exceed \$750,000 for any calendar year. The assessment shall be apportioned and assessed and paid as prescribed by § 38.2-403 at the rate determined by the Office of the Attorney General. The Office of the Attorney General shall notify the Commission of the assessment rate on or before December 1 of each year. The Commission shall be reimbursed from the fund for all necessary expenses for the administration of this section.

The assessments made by the Commission and paid into the state treasury shall be deposited to a special fund designated "State Managed Care Consumer Advocate Fund," to be maintained by the Division of Consumer Counsel of the Office of the Attorney General, and out of such special fund and the unexpended balance thereof shall be appropriated the sums necessary for accomplishing the powers and duties assigned to the Division of Consumer Counsel of the Office of the Attorney General under this chapter. All interest earned the deposit of moneys accumulated in the Fund shall be deposited in the Fund for the same use.

The moneys deposited in the Fund shall not be considered general revenue of the Commonwealth but shall be used only to (i) effectuate the purposes enumerated in this chapter and (ii) reimburse the Commission for its necessary expenses for the administration of this section. The Fund shall be subject to audit by the Auditor of Public Accounts.

In the event that this Fund is dissolved by operation of law or otherwise, any balance remaining in the Fund, after deducting administrative costs associated with the dissolution, shall be returned to insurers in proportion to their financial contributions to the Fund in the preceding calendar year.

2. That the State Commission shall promulgate the first set of regulations to implement the provisions of Chapter 59 of Title 38.2 of this act to be effective within 280 days of the enactment of this provision.

3. This act shall take effect on July 1, 1999; however, the appeal processes set forth in Chapter 59 of Title 38.2 of this act shall not take effect until the earlier of (i) ninety days following the promulgation of regulations by the State Corporation Commission as set forth in § 38.2-5904 or (ii) July 1, 2000.