COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

KATHY BYRON
523 LEESVILLE ROAD
LYNCHBURG, VIRGINIA 24502

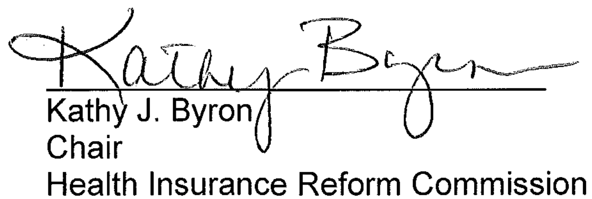
TWENTY-SECOND DISTRICT

COMMITTEE ASSIGNMENTS:
COMMERCE AND LABOR (VICE CHAIRMAN)
FINANCE
SCIENCE AND TECHNOLOGY

January 14, 2015

To: The Governor and the General Assembly
and
The House Committee on Commerce and Labor
and
The Senate Committee on Commerce and Labor
of the General Assembly of Virginia

The Executive Summary contained herein has been prepared pursuant to §§ 30-339 through 30-346 of the Code of Virginia. This summary documents the activities of the Health Insurance Reform Commission in 2014.



Kathy J. Byron
Chair
Health Insurance Reform Commission

DISTRICT: (434) 582-1592 • RICHMOND: (804) 698-1022 • E-MAIL: KATHY@KATHYBYRON.COM

EXECUTIVE SUMMARY OF THE

HEALTH INSURANCE REFORM COMMISSION

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRGINIA
RICHMOND
DECEMBER 2014

HEALTH INSURANCE REFORM COMMISSION

MEMBERS OF THE GENERAL ASSEMBLY

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Senator Frank W. Wagner
Senator John C. Watkins

EX OFFICIO MEMBERS

William A. Hazel, Jr. M.D., Secretary of Health and Human Resources
Jacqueline Cunningham, Commissioner of Insurance

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AUTHORITY AND HISTORY

The Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) was created in 1990 to evaluate the social and financial impact and medical efficacy of existing and proposed mandated health insurance benefits and providers. Sections 2.2-2503 through 2.2-2505 of the Code of Virginia provided for the establishment and organization of the Advisory Commission. Section 2.2-2503 required that the Advisory Commission report to the Governor and the General Assembly on the interim activity and the work of the Commission no later than the first day of the regular session of the General Assembly.

The sections governing the Advisory Commission were repealed by the passage of House Bill 2138 in the 2013 Session of the General Assembly (See Appendix A).

House Bill 2138 created the Health Insurance Reform Commission (HIRC). Sections 30-339 through 30-345 establish the HIRC in the legislative branch of government. The HIRC consists of 10 members. Four of the members are from the House Committee on Commerce and Labor and are appointed by the Speaker of the House. Four legislative members are from the Senate Committee on Commerce and Labor and are appointed by the Senate Committee on Rules. The Secretary of Health and Human Resources and the Commissioner of Insurance, or their designees, are non-voting ex officio members.

Section 30-342 contains the following powers and duties of the HIRC:

- Monitor the work of appropriate federal and state agencies in implementing the provisions of the federal Patient Protection and Affordable Care Act (the Act), including amendments thereto and regulations promulgated thereunder the Act;

- Assess the implications of the Act's implementation on residents of the Commonwealth, businesses operating within the Commonwealth, and the general fund of the Commonwealth;

- Consider the recommendations of the Virginia Health Reform Initiative to the Governor regarding the development of a comprehensive strategy for implementing health reform in Virginia, including recommendations for innovative health care solutions independent of the approach embodied in the Act that meet the needs of Virginia's citizens and government by creating an improved health system that will serve as an economic driver for the Commonwealth while allowing for more effective and efficient delivery of high quality care at lower cost;

- Determine whether, when, and under what conditions the Commonwealth should establish a state-run health benefit exchange, partner with the federal government to implement a health benefit exchange, or acquiesce in the establishment of a federally operated health benefit exchange in Virginia;

- Recommend what health benefits should be required to be included within the scope of the essential health benefits provided under health insurance products offered in the Commonwealth, including any benefits that are not required to be provided by the terms of the Act;

- Provide assessments of existing and proposed mandated health insurance benefits and providers, including assessments of whether such a mandate (i) is included in the essential health benefits required by federal law to be provided under a health care plan and (ii) should be provided under health care plans offered through a health benefit exchange, outside a health benefit exchange, neither or both;

- Conduct other studies of mandated benefits and provider issues as requested by the General Assembly; and

- Develop such recommendations as may be appropriate for legislative and administrative consideration in order to increase access to health insurance coverage, ensure that the costs to business and individual purchasers of health insurance coverage are reasonable, and encourage a robust market for health insurance products in the Commonwealth.

Section 30-343 provides that standing committees with jurisdiction over proposals for a mandated health insurance benefit or provider must request that the HIRC prepare a study of the proposal if a mandated benefit or provider measure is proposed. The study must assess the social and financial impact and medical efficacy of the proposal. The HIRC must be given 24 months to complete the study and submit the assessment. If a proposal is identical or substantially similar to a legislative measure reviewed in the three-year period prior to the current session of the General Assembly, the study may be requested.

Section 30-344 establishes a requirement that administrative staff support be provided by the Office of the Clerk of the House or Office of the Clerk of the Senate as appropriate, and that staff assistance is to be provided by the Bureau of Insurance of the State Corporation Commission and the Joint Legislative Audit and Review Commission, as well as other state agencies considered appropriate by the HIRC. All agencies of the Commonwealth must provide assistance to the HIRC when requested.

An annual Executive Summary must be provided by the chair of the HIRC by the first day of the regular session of the General Assembly. This document presents a summary of the activities of the HIRC during 2014.

The chapter creating the HIRC expires on July 1, 2017.

MEETINGS OF THE HEALTH INSURANCE REFORM COMMISSION

Meeting of September 10, 2014

The Health Insurance Reform Commission met on September 10, 2014. Three staff members of the Life and Health Division of the Bureau of Insurance (Bureau) made presentations to the HIRC. Information was provided on the review process for mandated benefits and provider proposals that was utilized by the former Special Advisory Commission on Mandated Health Insurance Benefits. A summary was included on the information that was presented by the Bureau staff members in the review of proposed mandates. A summary was also provided on the two bills that were referred to the HIRC in the 2014 Session. Senate Bill 275 revises the current mandate of coverage for victims of rape or incest by adding a provision that would prohibit cost-sharing requirements for HIV prevention medications for victims of sexual assault, (See Appendix B). House Bill 1185 revises the current mandate of coverage for inpatient treatment for mental health and substance abuse services to place additional requirements on insurers in determining the level of care that is authorized for insureds and the reimbursement for the level of care that is received (See Appendix C). Information was also presented on the effect of the Patient Protection and Affordable Care Act's (ACA) essential health benefits (EHBs) provisions and the Benchmark plan on Virginia's mandated benefits.

Bureau staff also provided information on the plan management functions conducted by the State Corporation Commission (SCC) and Virginia Department of Health pursuant to the ACA. The presentation included information on the process for reviewing and approving plans that will be offered in the federal Marketplace and Small Business Health Options Program (SHOP). Information on on the types of plans offered in 2014 and those available in 2015 was provided. Bureau staff described significant changes in health insurance coverage that have occurred since the enactment of the ACA and provided informationon the number and types of health insurance complaints and inquiries received by the Bureau in the past two years.. The Navigator process and the registration requirements and effects of House Bill 2043 (2014) were also reviewed.

During this meeting, Bureau staff also presented information on Virginia's rate regulation process prior to July 1, 2013 and the changes that occurred after July 1, 2013. Details regarding the rating variables that were used in individual and small group rating were provided. Examples of information presented at the 2014 and 2015 rate presentations on ACA rates were provided and the impact of certain ACA provisions on actual rates for certain individuals was explained.

Doug Gray, representing the Virginia Health Insurance Plans, also addressed the HIRC. He provided information on the impact of ACA requirements on Virginia's market and he discussed impending market changes because of the non-renewals expected for plans that do not comply with ACA requirements. Mr. Gray also addressed the impact of EHBs and the Benchmark plan on future mandated benefits proposals.

The HIRC discussed the impact of the ACA and additional changes that are possible for the EHB's and Benchmark plans in the future. Members also discussed the possible cost to the Commonwealth of enacting additional mandated benefits or changes to existing benefits that increase premiums. As a result of the members' discussions, the HIRC did not adopt a review process for legislation referred to the HIRC. The members did vote to recommend that Senate Bill 275 and House Bill 1185 be tabled permanently.

Meeting of October 27, 2014

The second HIRC meeting of the year was held on October 27, 2014. Commissioner of Insurance Jacqueline Cunningham provided information to the HIRC on current activity in the health insurance market in Virginia. Commissioner Cunningham provided information on the number of carriers operating in Virginia at the present time as well as updates on the Navigator process that assists consumers in their efforts to utilize the federal marketplace. She also provided updates on the plan management functions of the Bureau along with the recommendations of the Bureau regarding qualified health plans. The upcoming open enrollment period for the federal marketplace was also discussed, as well as the 2015 legislative session.

Delegate Byron mentioned a form that was submitted to her by staff of the Joint Legislative Audit and Review Commission (JLARC) that could be used when bills are introduced which would not require review from the HIRC because the coverage under the bill is already provided in the EHBs, or because of some other reason. Delegate Byron noted that a form of this type might be beneficial when legislation is referred to committees prior to being assigned to the HIRC.

Also during this meeting, a presentation on the implementation of the ACA was made by Joanne Grossi, a Regional Director of the U.S. Department of Health and Human Services. Ms. Grossi provided information on the impact of the ACA nationwide along with Virginia's results. Ms. Grossi noted that up to 8 million people signed up for coverage in the federal marketplace. Also, 3.1 million young people can now stay on their parents' coverage until they reach age 26. The rate of uninsured was 18% prior to implementation of the Act and the rate is now down to 13.4% of the population.

Members of the HIRC asked a number of questions, including the number of people who lost coverage and could not afford to replace it and information on those who do not pay health care providers and hospitals when the expenses are applied to the deductible.

Ms. Grossi indicated that some information specific to Virginia is available and she would forward it to Delegate Byron. She stated that premiums for some people have increased, but premiums for others have decreased.

The information received from Ms. Grossi indicates that over 200,000 individuals in Virginia selected a marketplace plan between October 1, 2013 and March 31, 2014. Virginia has received over $6 million in grants for research, planning, information technology development and marketplace implementation.

An additional 60,000 Virginians have received Medicaid or CHIP (Children's Health Insurance Plan) coverage. There are 66,000 young Virginians included in the 3 million young adults in the country covered because of ACA requirements to provide dependent coverage to age 26. The removal of lifetime dollar limits on health benefits has impacted nearly 3 million people in Virginia based in information provided by Ms. Grossi. The information is available on the marketplace website.

Doug Gray, Executive Director of the Virginia Association of Health Plans, also spoke at the meeting. Mr. Gray responded to questions about the premium impact of ACA reforms and nonrenewal of policies that did not meet federal requirements. He noted that by using higher deductibles, premium increases can be reduced. Mr. Gray also discussed the inclusion of specialists in carriers' networks. He noted that often people do not check on the providers in a health plan's network before they make a plan selection. He noted that the America's Health Insurance Plans, the national trade organization representing many health insurers, has a guide to assist consumers in understanding networks in health insurance plans.

A presentation was also made by Kevin Kuhlman, a manager of Federal Public Policy for the National Federation of Independent Business (NFIB). Mr. Kuhlman provided information on how the ACA has impacted small businesses based on responses to a longitudinal survey and anecdotally from feedback from small business owners. Mr. Kuhlman said that the anecdotal comments indicate the experience of the businesses has been negative, and the scientific survey data verifies the negative anecdotal experience.

Mr. Kuhlman noted that implementation challenges in the individual and small group markets caused by delayed or changing provisions of the ACA. He discussed the

revised employer mandate; the federal government allowing noncompliant plans to be sold for one to three years beyond the original deadline; and the delay in the Small Business Health Options Programs (SHOP) as significant issues for small businesses.

Mr. Kuhlman noted that the cost of health insurance has been the number one concern for small businesses since 1986. However, from NFIB's perspective, the ACA appears to be accelerating the cost increases. He supplied information from NFIB's Research Foundation indicating that 59% of small businesses had premium increases last year. Mr. Kuhlman provided information from the U.S. Department of Health and Human Services (HHS) and Internal Revenue Service's data.

Mr. Kuhlman discussed the costs associated with the EHB package of benefits. He suggested that if HHS allows states to designate the EHBs, Virginia should focus on affordability. He sees the EHBs and SHOP development as areas state lawmakers may be able to focus on to address affordability and flexibility.

There was additional discussion of the upcoming legislative session and the impact of possible ACA changes. The HIRC will continue to monitor the ACA changes and provide information to the legislative committees during the 2015 session.

APPENDIX A

VIRGINIA ACTS OF ASSEMBLY -- 2013 SESSION

CHAPTER 709

An Act to amend and reenact §§ 2.2-2818, 30-58.1, and 38.2-3431 of the Code of Virginia; to amend the Code of Virginia by adding in Title 30 a chapter numbered 53, consisting of sections numbered 30-339 through 30-346; and to repeal Article 2 (§§ 2.2-2503, 2.2-2504, and 2.2-2505) of Chapter 25 of Title 2.2 of the Code of Virginia, relating to the establishment of the Health Insurance Reform Commission; repeal of the Special Advisory Commission on Mandated Health Insurance Benefits.

[H 2138]

Approved March 23, 2013

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2818, 30-58.1, and 38.2-3431 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Title 30 a chapter numbered 53, consisting of sections numbered 30-339 through 30-346, as follows:

§ 2.2-2818. Health and related insurance for state employees.

A. The Department of Human Resource Management shall establish a plan, subject to the approval of the Governor, for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The same plan shall be offered to all part-time state employees, but the total cost shall be paid by such part-time employees. The Department of Human Resource Management shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. Except for part-time employees, the Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee, including a part-time employee, may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

1. Include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over and may be limited to a benefit of $50 per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally.

The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

In order to be considered a screening mammogram for which coverage shall be made available under this section:

a. The mammogram shall be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization provider; (ii) performed by a registered technologist; (iii) interpreted by a qualified radiologist; and (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body. A copy of the mammogram report shall be sent or delivered to the health care practitioner who ordered it;

b. The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

c. The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

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

3. Include an appeals process for resolution of complaints that shall provide reasonable procedures for the resolution of such complaints and shall be published and disseminated to all covered state employees. The appeals process shall be compliant with federal rules and regulations governing

nonfederal, self-insured governmental health plans. The appeals process shall include a separate expedited emergency appeals procedure that shall provide resolution within time frames established by federal law. For appeals involving adverse decisions as defined in § 32.1-137.7, the Department shall contract with one or more independent review organizations to review such decisions. Independent review organizations are entities that conduct independent external review of adverse benefit determinations. The Department shall adopt regulations to assure that the independent review organization conducting the reviews has adequate standards, credentials and experience for such review. The independent review organization shall examine the final denial of claims to determine whether the decision is objective, clinically valid, and compatible with established principles of health care. The decision of the independent review organization shall (i) be in writing, (ii) contain findings of fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if consistent with law and policy.

Prior to assigning an appeal to an independent review organization, the Department shall verify that the independent review organization conducting the review of a denial of claims has no relationship or association with (i) the covered person or the covered person's authorized representative; (ii) the treating health care provider, or any of its employees or affiliates; (iii) the medical care facility at which the covered service would be provided, or any of its employees or affiliates; or (iv) the development or manufacture of the drug, device, procedure or other therapy that is the subject of the final denial of a claim. The independent review organization shall not be a subsidiary of, nor owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers. There shall be no liability on the part of and no cause of action shall arise against any officer or employee of an independent review organization for any actions taken or not taken or statements made by such officer or employee in good faith in the performance of his powers and duties.

4. Include coverage for early intervention services. For purposes of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention services for the population certified by the Department of Behavioral Health and Developmental Services shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the insured's lifetime.

5. Include coverage for prescription drugs and devices approved by the United States Food and Drug Administration for use as contraceptives.

6. Not deny coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, if the drug has been recognized as safe and effective for treatment of that specific type of cancer in one of the standard reference compendia.

7. Not deny coverage for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

8. Include coverage 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 healthcare professional legally authorized to prescribe such items under law. To qualify for coverage under this subdivision, diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

9. Include coverage for reconstructive breast surgery. For purposes of this section, "reconstructive breast surgery" means surgery performed on and after July 1, 1998, (i) coincident with a mastectomy performed for breast cancer or (ii) following a mastectomy performed for breast cancer to reestablish symmetry between the two breasts. For persons previously covered under the plan, there shall be no denial of coverage due to preexisting conditions.

10. Include coverage for annual pap smears, including coverage, on and after July 1, 1999, for annual testing performed by any FDA-approved gynecologic cytology screening technologies.

11. Include coverage providing a minimum stay in the hospital of not less than 48 hours for a patient following a radical or modified radical mastectomy and 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the

attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

12. Include coverage (i) to persons age 50 and over and (ii) to persons age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

13. Permit any individual covered under the plan direct access to the health care services of a participating specialist (i) authorized to provide services under the plan and (ii) selected by the covered individual. The plan shall have a procedure by which an individual who has an ongoing special condition may, after consultation with the primary care physician, 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, the plan shall refer the individual to a specialist. For the purposes of this subdivision, "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. 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 related to the initial referral as the individual's primary care provider would otherwise be permitted to provide or authorize. The plan shall have a procedure by which an individual 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 primary care provider, in consultation with the plan 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. Nothing contained herein shall prohibit the plan 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.

14. Include provisions allowing employees to continue receiving health care services for a period of up to 90 days from the date of the primary care physician's notice of termination from any of the plan's provider panels. The plan shall notify any provider at least 90 days prior to the date of termination of the provider, except when the provider is terminated for cause.

For a period of at least 90 days from the date of the notice of a provider's termination from any of the plan's provider panels, except when a provider is terminated for cause, a provider shall be permitted by the plan to render health care services to any of the covered employees who (i) were in an active course of treatment from the provider prior to the notice of termination and (ii) request to continue receiving health care services from the provider.

Notwithstanding the provisions of this subdivision, any provider shall be permitted by the plan to continue rendering health services to any covered employee who has entered the second trimester of pregnancy at the time of the provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue through the provision of postpartum care directly related to the delivery.

Notwithstanding the provisions of this subdivision, any provider shall be permitted to continue rendering health services to any covered employee who is determined to be 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 covered employee's option, continue for the remainder of the employee's life for care directly related to the treatment of the terminal illness.

A provider who continues to render health care services pursuant to this subdivision shall be reimbursed in accordance with the carrier's agreement with such provider existing immediately before the provider's termination of participation.

15. Include coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials.

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

For purposes of this subdivision:

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

"FDA" means the Federal Food and Drug Administration.

"Multiple project assurance contract" means a contract between an institution and the federal

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

"NCI" means the National Cancer Institute.

"NIH" means the National Institutes of Health.

"Patient" means a person covered under the plan established pursuant to this section.

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

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

The treatment described in the previous paragraph shall be provided by a clinical trial approved by:

a. The National Cancer Institute;

b. An NCI cooperative group or an NCI center;

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

d. The federal Department of Veterans Affairs; or

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

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

Coverage under this subdivision shall apply only if:

(1) There is no clearly superior, noninvestigational treatment alternative;

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

(3) The patient and the physician or health care provider who provides services to the patient under the plan conclude that the patient's participation in the clinical trial would be appropriate, pursuant to procedures established by the plan.

16. Include coverage providing a minimum stay in the hospital of not less than 23 hours for a covered employee following a laparoscopy-assisted vaginal hysterectomy and 48 hours for a covered employee following a vaginal hysterectomy, as outlined in Milliman & Robertson's nationally recognized guidelines. Nothing in this subdivision shall be construed as requiring the provision of the total hours referenced when the attending physician, in consultation with the covered employee, determines that a shorter hospital stay is appropriate.

17. Include coverage for biologically based mental illness.

For purposes of this subdivision, a "biologically based mental illness" is any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's functioning; specifically, the following diagnoses are defined as biologically based mental illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.

Coverage for biologically based mental illnesses 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.

Nothing shall preclude the undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of biologically based mental illnesses 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.

18. Offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally. Access to surgery for morbid obesity shall not be restricted based upon dietary or any other criteria not approved by the National Institutes of Health. For purposes of this subdivision, "morbid obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of

40 kilograms per meter squared without such comorbidity. As used herein, "BMI" equals weight in kilograms divided by height in meters squared.

19. Include coverage for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations. The coverage for colorectal cancer screening shall not be more restrictive than or separate from coverage provided 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 copayments and coinsurance factors.

20. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each employee provided coverage pursuant to this section, and shall upon any changes in the required data elements set forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide employees covered under the plan such corrective information as may be required to electronically process a prescription claim.

21. Include coverage for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such coverage shall include follow-up audiological examinations as recommended by a physician, physician assistant, nurse practitioner or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

22. Notwithstanding any provision of this section to the contrary, every plan established in accordance with this section shall comply with the provisions of § 2.2-2818.2.

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The funds of the health insurance fund shall be deemed separate and independent trust funds, shall be segregated from all other funds of the Commonwealth, and shall be invested and administered solely in the interests of the employees and their beneficiaries. Neither the General Assembly nor any public officer, employee, or agency shall use or authorize the use of such trust funds for any purpose other than as provided in law for benefits, refunds, and administrative expenses, including but not limited to legislative oversight of the health insurance fund.

D. For the purposes of this section:

"Part-time state employees" means classified or similarly situated employees in legislative, executive, judicial or independent agencies who are compensated on a salaried basis and work at least 20 hours, but less than 32 hours, per week.

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

"Standard reference compendia" means:

1. American Hospital Formulary Service - Drug Information;
2. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
3. Elsevier Gold Standard's Clinical Pharmacology.

"State employee" means state employee as defined in § 51.1-124.3; employee as defined in § 51.1-201; the Governor, Lieutenant Governor and Attorney General; judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth; and interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Virginia Commonwealth University Health System Authority as provided in § 23-50.16:24.

E. Provisions shall be made for retired employees to obtain coverage under the above plan, including, as an option, coverage for vision and dental care. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

F. Any self-insured group health insurance plan established by the Department of Human Resource Management that utilizes a network of preferred providers shall not exclude any physician solely on the basis of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan criteria established by the Department.

G. The plan shall include, in each planning district, at least two health coverage options, each

sponsored by unrelated entities. No later than July 1, 2006, one of the health coverage options to be available in each planning district shall be a high deductible health plan that would qualify for a health savings account pursuant to § 223 of the Internal Revenue Code of 1986, as amended.

In each planning district that does not have an available health coverage alternative, the Department shall voluntarily enter into negotiations at any time with any health coverage provider who seeks to provide coverage under the plan.

This subsection shall not apply to any state agency authorized by the Department to establish and administer its own health insurance coverage plan separate from the plan established by the Department.

H. Any self-insured group health insurance plan established by the Department of Human Resource Management that includes coverage for prescription drugs on an outpatient basis may apply a formulary to the prescription drug benefits provided by the plan if the formulary is developed, reviewed at least annually, and updated as necessary in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of whose members are actively practicing licensed (i) pharmacists, (ii) physicians, and (iii) other health care providers.

If the plan maintains one or more drug formularies, the plan shall establish a process to allow a person to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the plan, a specific, medically necessary nonformulary prescription drug if, after reasonable investigation and consultation with the prescriber, the formulary drug is determined to be an inappropriate therapy for the medical condition of the person. The plan shall act on such requests within one business day of receipt of the request.

Any plan established in accordance with this section shall be authorized to provide for the selection of a single mail order pharmacy provider as the exclusive provider of pharmacy services that are delivered to the covered person's address by mail, common carrier, or delivery service. As used in this subsection, "mail order pharmacy provider" means a pharmacy permitted to conduct business in the Commonwealth whose primary business is to dispense a prescription drug or device under a prescriptive drug order and to deliver the drug or device to a patient primarily by mail, common carrier, or delivery service.

I. Any plan established in accordance with this section requiring preauthorization prior to rendering medical treatment shall have personnel available to provide authorization at all times when such preauthorization is required.

J. Any plan established in accordance with this section shall provide to all covered employees written notice of any benefit reductions during the contract period at least 30 days before such reductions become effective.

K. No contract between a provider and any plan established in accordance with this section shall include provisions that require a health care provider or health care provider group to deny covered services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a covered employee with similar medical conditions.

L. The Department of Human Resource Management shall appoint an Ombudsman to promote and protect the interests of covered employees under any state employee's health plan.

The Ombudsman shall:

1. Assist covered employees in understanding their rights and the processes available to them according to their state health plan.

2. Answer inquiries from covered employees by telephone and electronic mail.

3. Provide to covered employees information concerning the state health plans.

4. Develop information on the types of health plans available, including benefits and complaint procedures and appeals.

5. Make available, either separately or through an existing Internet web site utilized by the Department of Human Resource Management, information as set forth in subdivision 4 and such additional information as he deems appropriate.

6. Maintain data on inquiries received, the types of assistance requested, any actions taken and the disposition of each such matter.

7. Upon request, assist covered employees in using the procedures and processes available to them from their health plan, including all appeal procedures. Such assistance may require the review of health care records of a covered employee, which shall be done only in accordance with the federal Health Insurance Portability and Accountability Act privacy rules. The confidentiality of any such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

8. Ensure that covered employees have access to the services provided by the Ombudsman and that the covered employees receive timely responses from the Ombudsman or his representatives to the inquiries.

9. Report annually on his activities to the standing committees of the General Assembly having jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of each year.

M. The plan established in accordance with this section shall not refuse to accept or make

reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by a covered employee.

For purposes of this subsection, "assignment of benefits" means the transfer of dental care coverage reimbursement benefits or other rights under the plan. The assignment of benefits shall not be effective until the covered employee notifies the plan in writing of the assignment.

N. Beginning July 1, 2006, any plan established pursuant to this section shall provide for an identification number, which shall be assigned to the covered employee and shall not be the same as the employee's social security number.

O. Any group health insurance plan established by the Department of Human Resource Management that contains a coordination of benefits provision shall provide written notification to any eligible employee as a prominent part of its enrollment materials that if such eligible employee is covered under another group accident and sickness insurance policy, group accident and sickness subscription contract, or group health care plan for health care services, that insurance policy, subscription contract or health care plan may have primary responsibility for the covered expenses of other family members enrolled with the eligible employee. Such written notification shall describe generally the conditions upon which the other coverage would be primary for dependent children enrolled under the eligible employee's coverage and the method by which the eligible enrollee may verify from the plan that coverage would have primary responsibility for the covered expenses of each family member.

P. Any plan established by the Department of Human Resource Management pursuant to this section shall provide that coverage under such plan for family members enrolled under a participating state employee's coverage shall continue for a period of at least 30 days following the death of such state employee.

Q. The plan established in accordance with this section that follows a policy of sending its payment to the covered employee or covered family member for a claim for services received from a nonparticipating physician or osteopath shall (i) include language in the member handbook that notifies the covered employee of the responsibility to apply the plan payment to the claim from such nonparticipating provider, (ii) include this language with any such payment sent to the covered employee or covered family member, and (iii) include the name and any last known address of the nonparticipating provider on the explanation of benefits statement.

R. The Department of Human Resource Management shall report annually, by November 30 of each year ~~in which a mandate is imposed under the provisions of § 2.2-2818.2, to the Special Advisory Commission on Mandated Health Insurance Benefits established pursuant to Article 2 (§ 2.2-2503 et seq.) of Chapter 25~~, on cost and utilization information for each of the mandated benefits set forth in subsection B, including any mandated benefit made applicable, pursuant to subdivision B 22, to any plan established pursuant to this section. The report shall be in the same detail and form as required of reports submitted pursuant to § 38.2-3419.1, with such additional information as is required to determine the financial impact, including the costs and benefits, of the particular mandated benefit.

§ 30-58.1. Powers and duties of Commission.

The Commission shall have the following powers and duties:

~~A.~~ *1.* Make performance reviews of operations of state agencies to ascertain that sums appropriated have been, or are being expended for the purposes for which such appropriations were made and to evaluate the effectiveness of programs in accomplishing legislative intent;

~~B.~~ *2.* Study on a continuing basis the operations, practices and duties of state agencies, as they relate to efficiency in the utilization of space, personnel, equipment and facilities;

~~C.~~ *3.* Make such special studies and reports of the operations and functions of state agencies as it deems appropriate and as may be requested by the General Assembly;

~~D.~~ *4.* Assess, analyze, and evaluate the social and economic costs and benefits of any proposed mandated health insurance benefit or mandated provider *that is not included in the essential health benefits required by federal law to be provided under a health care plan*, including~~, but not limited to,~~ the mandate's predicted effect on health care coverage premiums and related costs, net costs or savings to the health care system, and other relevant issues, and report its findings with respect to the proposed mandate to the ~~Special Advisory~~ *Health Insurance Reform* Commission ~~on Mandated Health Insurance Benefits~~; and

~~E.~~ *5.* Make such reports on its findings and recommendations at such time and in such manner as the Commission deems proper submitting same to the agencies concerned, to the Governor and to the General Assembly. Such reports as are submitted shall relate to the following matters:

~~1.~~ *a.* Ways in which the agencies may operate more economically and efficiently;

~~2.~~ *b.* Ways in which agencies can provide better services to the Commonwealth and to the people; and

~~3.~~ *c.* Areas in which functions of state agencies are duplicative, overlapping, or failing to accomplish legislative objectives or for any other reason should be redefined or redistributed.

CHAPTER 53.

HEALTH INSURANCE REFORM COMMISSION.

§ 30-339. Health Insurance Reform Commission established; membership; terms.

A. The Health Insurance Reform Commission (the Commission) is established in the legislative branch of state government.

B. The Commission shall consist of 10 members that include eight legislative members and two nonvoting ex officio members as follows: four members of the House Committee on Commerce and Labor appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates; four members of the Senate Committee on Commerce and Labor appointed by the Senate Committee on Rules; and the Secretary of Health and Human Resources and the Commissioner of Insurance, or their designees.

C. Members of the Commission shall serve terms coincident with their terms of office. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments. All members may be reappointed.

D. The Commission annually shall elect a chairman and vice-chairman from among its membership, who shall be members of the General Assembly.

§ 30-340. Quorum; meetings; voting on recommendations.

A. A majority of the members shall constitute a quorum. The meetings of the Commission shall be held at the call of the chairman or whenever the majority of the members so request.

B. No recommendation of the Commission shall be adopted if a majority of the Senate members or a majority of the House members appointed to the Commission (i) vote against the recommendation and (ii) vote for the recommendation to fail notwithstanding the majority vote of the Commission.

§ 30-341. Compensation; expenses.

Legislative members of the Commission shall receive such compensation as provided in § 30-19.12. All members shall be reimbursed for all reasonable and necessary expenses incurred in the performance of their duties as provided in §§ 2.2-2813 and 2.2-2825. Funding for the compensation and costs of expenses of members shall be provided by the State Corporation Commission.

§ 30-342. Powers and duties.

The Commission shall have the following powers and duties:

1. Monitor the work of appropriate federal and state agencies in implementing the provisions of the federal Patient Protection and Affordable Care Act, including amendments thereto and regulations promulgated thereunder (the Act);

2. Assess the implications of the Act's implementation on residents of the Commonwealth, businesses operating within the Commonwealth, and the general fund of the Commonwealth;

3. Consider the recommendations of the Virginia Health Reform Initiative to the Governor regarding the development of a comprehensive strategy for implementing health reform in Virginia, including recommendations for innovative health care solutions independent of the approach embodied in the Act that meet the needs of Virginia's citizens and government by creating an improved health system that will serve as an economic driver for the Commonwealth while allowing for more effective and efficient delivery of high quality care at lower cost;

4. Determine whether, when, and under what conditions the Commonwealth should establish a state-run health benefit exchange, partner with the federal government to implement a health benefit exchange, or acquiesce in the establishment of a federally operated health benefit exchange within Virginia;

5. Recommend what health benefits should be required to be included within the scope of the essential health benefits provided under health insurance products offered in the Commonwealth, including any benefits that are not required to be provided by the terms of the Act;

6. Provide assessments of existing and proposed mandated health insurance benefits and providers, including assessments of whether such a mandate (i) is included in the essential health benefits required by federal law to be provided under a health care plan and (ii) should be provided under health care plans offered through a health benefit exchange, outside a health benefit exchange, neither, or both;

7. Conduct other studies of mandated benefits and provider issues as requested by the General Assembly; and

8. Develop such recommendations as may be appropriate for legislative and administrative consideration in order to increase access to health insurance coverage, ensure that the costs to business and individual purchasers of health insurance coverage are reasonable, and encourage a robust market for health insurance products in the Commonwealth.

§ 30-343. Standing committees to request Commission study.

A. Whenever a legislative measure containing a mandated health insurance benefit or provider is proposed, the standing committee of the General Assembly having jurisdiction over the proposal shall request that the Commission prepare a study that assesses the social and financial impact and the medical efficacy of the proposed mandate. The Commission shall be given a period of 24 months to complete and submit its assessment. A report summarizing the Commission's study shall be forwarded to the Governor and the General Assembly.

B. Whenever a legislative measure containing a mandated health insurance benefit or provider is identical or substantially similar to a legislative measure previously reviewed by the Commission within the three-year period immediately preceding the then current session of the General Assembly, the

standing committee may request the Commission to study as provided in subsection A.

§ 30-344. Staffing.

Administrative staff support for the Commission shall be provided by the Office of the Clerk of the Senate or the Office of Clerk of the House of Delegates as may be appropriate for the house in which the chairman of the Commission serves. The Bureau of Insurance of the State Corporation Commission, the Joint Legislative Audit and Review Commission, and such other state agencies as may be considered appropriate by the Commission shall provide staff assistance to the Commission. All agencies of the Commonwealth shall provide assistance to the Commission, upon request.

§ 30-345. Chairman's executive summary of activity and work of the Commission.

The chairman of the Commission shall submit to the Governor and the General Assembly an annual executive summary of the interim activity and work of the Commission no later than the first day of each regular session of the General Assembly. The executive summary shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

§ 30-346. Sunset.

This chapter shall expire on July 1, 2017.

§ 38.2-3431. Application of article; definitions.

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

Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing individual or group accident and sickness subscription contracts, and each health maintenance organization or multiple employer welfare arrangement providing health care plans for health care services that offers individual or group coverage to the small employer market in this Commonwealth shall be subject to the provisions of this article. Any issuer of individual coverage to employees of a small employer shall be subject to the provisions of this article if any of the following conditions are met:

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

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

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

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

B. For the purposes of this article:

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

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

1. Such period shall begin on the enrollment date.

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

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

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

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

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

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

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

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

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

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

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

"COBRA continuation provision" means any of the following:

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

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

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

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

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

1. A group health plan;

2. Health insurance coverage;

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

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

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

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

7. A state health benefits risk pool;

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

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

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

11. Individual health insurance coverage.

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

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

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

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

1. In accordance with the terms of such plan;

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

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

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

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

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

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

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

1. Benefits not subject to requirements of this article:

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

b. Coverage issued as a supplement to liability insurance;

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

d. Workers' compensation or similar insurance;

e. Medical expense and loss of income benefits;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

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

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

a. Limited scope dental or vision benefits;

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

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

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

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

b. Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

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

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

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

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

"Health maintenance organization" means:

1. A federally qualified health maintenance organization;

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

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

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

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

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

insurance coverage does not include short-term limited duration coverage.

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

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

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

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

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

"Medical care" means amounts paid for:

1. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
2. Transportation primarily for and essential to medical care referred to in subdivision 1; and
3. Insurance covering medical care referred to in subdivisions 1 and 2.

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

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

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

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

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

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

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

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

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

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

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

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

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

C. The Commission shall adopt regulations establishing the essential and standard plans for sale in the small employer market. Such regulations shall incorporate the recommendations of the Essential Health Services Panel, established pursuant to Chapter 847 of the 1992 Acts of Assembly. ~~The~~

~~Commission shall modify such regulations as necessary to incorporate any revisions to the essential and standard plans submitted by the Special Advisory Commission on Mandated Health Insurance Benefits pursuant to § 2.2-2503.~~ Every health insurance issuer shall, as a condition of transacting business in Virginia with small employers, offer to small employers the essential and standard plans, subject to the provisions of § 38.2-3432.2. However, any regulation adopted by the Commission shall contain a provision requiring all health insurance issuers to offer an option permitting a small employer electing to be covered under either an essential or standard health benefit plan to choose coverage that does not provide dental benefits. The regulation shall also require a small employer electing such option, as a condition of continuing eligibility for coverage pursuant to this article, to purchase separate dental coverage for all eligible employees and eligible dependents from a dental services plan authorized pursuant to Chapter 45 of this title. All health insurance issuers shall issue the plans to every small employer that elects to be covered under either one of the plans and agrees to make the required premium payments, and shall satisfy the following provisions:

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

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

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

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

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

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

b. If the Commission determines that acceptance of an application or applications would result in the health insurance issuer being declared an impaired insurer.

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

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

issuer's service area.

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

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

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

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

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

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

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

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

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

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

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

9. All essential and standard health benefits plans contracts delivered, issued for delivery, reissued, renewed, or extended in this Commonwealth on or after July 1, 1997, shall include coverage for 365 days of inpatient hospitalization for each covered individual during a 12-month period. If coverage under the essential or standard health benefits plan terminates while a covered person is hospitalized, the inpatient hospital benefits shall continue to be provided until the earliest of (i) the day the maximum amount of benefit has been provided or (ii) the day the covered person is no longer hospitalized as an inpatient.

2. That Article 2 (§§ 2.2-2503, 2.2-2504, and 2.2-2505) of Chapter 25 of Title 2.2 of the Code of Virginia is repealed.

APPENDIX B

14103179D

SENATE BILL NO. 275

Offered January 8, 2014

Prefiled January 5, 2014

A BILL to amend and reenact § 38.2-3418 of the Code of Virginia, relating to health insurance coverage for victims of sexual assault; cost-sharing requirements for HIV prevention medication.

Patron—Favola

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3418 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3418. Coverage for victims of rape or incest*; cost-sharing requirements for HIV prevention medication*.

Each hospital expense, medical-surgical expense, major medical expense, or hospital confinement indemnity insurance policy issued by an insurer, each individual and group subscription contract providing hospital, medical, or surgical benefits issued by a corporation, and each contract issued by a health maintenance organization ~~which~~ *that* provide benefits as a result of an "accident" or "accidental injury" shall be construed to ~~include~~*:*

1. Include benefits for pregnancy following an act of rape of an insured or subscriber ~~which~~ *that* was reported to the police within seven days following its occurrence, to the same extent as any other covered accident. The ~~7-day~~ *seven-day* requirement shall be extended to 180 days in the case of an act of rape or incest of a female under 13 years of age*; and*

2. Prohibit the insurer, corporation, or health maintenance organization from imposing on an insured, subscriber, or enrollee who is the victim of sexual assault as set out in Article 7 (§ 18.2-61 et seq.) of Chapter 4 of Title 18.2 any cost-sharing requirement, including a co-payment, coinsurance, deductible, or other dollar limit provision, with respect to any medication prescribed to prevent HIV in that person. The prohibition set forth in this subdivision shall apply notwithstanding the failure of the insured, subscriber, or enrollee to report the sexual assault to the police; however, if the insured, subscriber, or enrollee fails to report the sexual assault to the police, the prohibition shall not apply unless (i) the insured, subscriber, or enrollee participates in an examination conducted under a Sexual Assault Nurse Examiner (SANE) Program or equivalent program and (ii) the results of the examination provide the basis for a determination that there is a high probability that the sexual assault has resulted in the transmission of HIV. This subdivision shall apply to any policy, contract, or plan, including any certificate or evidence of coverage issued in connection with such policy, contract, or plan, that includes coverage for medication prescribed to prevent HIV. As used in this subdivision, "HIV" means the human immunodeficiency virus or any other related virus that causes acquired immunodeficiency syndrome. This subdivision shall apply to contracts, policies, or plans delivered, issued for delivery, or renewed in the Commonwealth on and after July 1, 2014.

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APPENDIX C

14103022D

HOUSE BILL NO. 1185

Offered January 16, 2014

A BILL to amend and reenact § 38.2-3412.1 of the Code of Virginia, relating to health insurance; coverage for mental health services.

Patrons—Spruill, Dance, Howell, A.T., Joannou, McClellan, O'Bannon and Ward

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Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3412.1 of the Code of Virginia is amended and reenacted as follows:

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

A. As used in this section:

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

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

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

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

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

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

"Mental health services" or "mental health benefits" means 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" or "substance use disorder benefits" 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, licensed marriage and family therapist or clinical nurse specialist who renders mental health services. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and

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59 rehabilitation as well as services rendered by a state certified alcoholism, drug, or substance abuse
60 counselor or substance abuse counseling assistant, limited to the scope of practice set forth in
61 § 54.1-3507.1 or 54.1-3507.2, respectively, employed by a facility or program licensed to provide such
62 treatment.
63 B. Except for group health insurance coverage issued to a large employer as defined in § 38.2-3431,
64 each individual and group accident and sickness insurance policy or individual and group subscription
65 contract providing coverage on an expense-incurred basis for a family member of the insured or the
66 subscriber shall provide coverage for inpatient and partial hospitalization mental health and substance
67 abuse services as follows:
68 1. Treatment for an adult as an inpatient at a hospital, inpatient unit of a mental health treatment
69 center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of 20
70 days per policy or contract year.
71 2. Treatment for a child or adolescent as an inpatient at a hospital, inpatient unit of a mental health
72 treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period
73 of 25 days per policy or contract year.
74 3. Up to 10 days of the inpatient benefit set forth in subdivisions 1 and 2 of this subsection may be
75 converted when medically necessary at the option of the person or the parent, as defined in § 16.1-336,
76 of a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula
77 which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for
78 each inpatient day of coverage. An insurance policy or subscription contract described herein that
79 provides inpatient benefits in excess of 20 days per policy or contract year for adults or 25 days per
80 policy or contract year for a child or adolescent may provide for the conversion of such excess days on
81 the terms set forth in this subdivision.
82 4. The limits of the benefits set forth in this subsection shall not be more restrictive than for any
83 other illness, except that the benefits may be limited as set out in this subsection.
84 5. This subsection shall not apply to short-term travel, accident only, limited or specified disease
85 policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage
86 under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under
87 state or federal governmental plans.
88 *6. The determination of whether the provision of inpatient treatment described in subdivision 1 or 2*
89 *is medically necessary shall give due consideration to the treatment recommendation of the health care*
90 *provider treating the individual. A denial of coverage for inpatient treatment or partial hospitalization*
91 *shall not be based primarily on a subjective evaluation of the imminence of the individual's suicide risk*
92 *or risk of danger to others made by an employee or contractor of the insurer or corporation if that*
93 *evaluation is inconsistent with the assessment of such risk made by the health care provider treating the*
94 *individual.*
95 *7. If (i) an insurer or corporation providing coverage for inpatient treatment or partial*
96 *hospitalization under this subsection validly denies coverage for such a benefit on the basis that a less*
97 *intensive treatment option, such as outpatient treatment, represents the medically necessary level of care*
98 *and (ii) the covered individual receives the more intensive treatment notwithstanding such denial of*
99 *coverage, then the insurer or corporation shall provide coverage for the more intensive treatment that*
100 *the covered individual received on the basis of the reimbursement and payment rates that would have*
101 *applied had the less intensive treatment been provided to the covered individual.*
102 C. Except for group health insurance coverage issued to a large employer as defined in § 38.2-3431,
103 each individual and group accident and sickness insurance policy or individual and group subscription
104 contract providing coverage on an expense-incurred basis for a family member of the insured or the
105 subscriber shall also provide coverage for outpatient mental health and substance abuse services as
106 follows:
107 1. A minimum of 20 visits for outpatient treatment of an adult, child or adolescent shall be provided
108 in each policy or contract year.
109 2. The limits of the benefits set forth in this subsection shall be no more restrictive than the limits of
110 benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit
111 beyond the first five of such visits covered in any policy or contract year shall be at least 50 percent.
112 3. For the purpose of this section, medication management visits shall be covered in the same
113 manner as a medication management visit for the treatment of physical illness and shall not be counted
114 as an outpatient treatment visit in the calculation of the benefit set forth herein.
115 4. For the purpose of this subsection, if all covered expenses for a visit for outpatient mental health
116 or substance abuse treatment apply toward any deductible required by a policy or contract, such visit
117 shall not count toward the outpatient visit benefit maximum set forth in the policy or contract.
118 5. This subsection shall not apply to short-term travel, accident only, or limited or specified disease
119 policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage
120 under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under

121 state or federal governmental plans.
122 D. The provisions of this section shall not be applicable to "biologically based mental illnesses," as
123 defined in § 38.2-3412.1:01, unless coverage for any such mental illness is not otherwise available
124 pursuant to the provisions § 38.2-3412.1:01.
125 E. The requirements of this section shall apply to all insurance policies and subscription contracts
126 delivered, issued for delivery, reissued, or extended, or at any time when any term of the policy or
127 contract is changed or any premium adjustment made.
128 F. Group health insurance coverage issued to a large employer as defined in § 38.2-3431 shall
129 provide mental health and substance use disorder benefits in parity with the medical and surgical
130 benefits contained in the coverage in accordance with the Mental Health Parity and Addiction Equity
131 Act of 2008 (P.L. 110-343).
132 G. The provisions of this section shall not apply in any instance in which the provisions of this
133 section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.