BUREAU OF INSURANCE

May 12, 1999

Administrative Letter 1999-3

TO: **All Insurers, Health Services Plans, Health Maintenance Organizations (HMOs) and Other Interested Parties**

RE: **Legislation Enacted by the 1999 Virginia General Assembly**

We have attached for your reference staff summaries of certain statutes enacted or amended and re-enacted during the 1999 Session of the Virginia General Assembly. **The effective date of these statutes is July 1, 1999, except as otherwise indicated in this letter.** Each organization to which this letter is being sent should review the attachments carefully and see that notice of these laws is directed to the proper persons, **including appointed representatives**, to ensure that appropriate action is taken to effect compliance with these new legal requirements. Please note that this document is a **summary** of legislation. It is neither a legal review and interpretation nor a full description of the legislative amendments made to insurance-related laws during the 1999 Session. Each organization is responsible for legal review of the statutes pertinent to its operations.

Cordially,

Alfred W. Gross
Commissioner of Insurance

AWG/dpb

Attachment

BUREAU OF INSURANCE
ADMINISTRATIVE LETTER 1999-3

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PROPERTY AND CASUALTY BILLS

Chapter 4 (Senate Bill 448)

This bill amends § 38.2-2204 by specifying that an insurer is not prohibited from limiting its liability to the policy's limits for any one accident regardless of the number of insureds under the policy. This language is being added as a result of the Virginia Supreme Court decision in Haislip v. Southern Heritage Insurance Company (254 Va. 265) in which the insurer was required to pay damages on behalf of the named insured for negligent entrustment even though the insurer had already paid the policy's limits on behalf of the permissive user who negligently operated the insured's vehicle.

Chapter 129 (House Bill 2307)

This bill amends § 38.2-517 by requiring the Commission to investigate any written complaints received pursuant to this section regardless of whether the complaint is submitted by an individual or a repair facility. The written authorization of the insured or the claimant must be obtained first. The bill also makes insurers, which use third parties, accountable for any violation of § 38.2-517 by the third party.

Chapter 491 (Senate Bill 1015)

This bill amends § 38.2-1903 by allowing workers' compensation large deductible plans for large risks to be exempt from the filing requirements of Chapter 19. Large risks are defined as those which generate a total estimated standard premium for workers' compensation insurance of at least $250,000 annually, or less or in combination with other lines if approved by the Commission. (The $250,000 minimum annual premium now applies to retrospective rating plans as well. This has been

changed from $500,000.) Large deductible plans are defined as workers' compensation rating plans that include a per-claim deductible of at least $100,000. A copy of any large deductible plan must be made available to the Commission upon request. Also, insurers' experience attributable to large risks must still be reported in accordance with the uniform statistical plan.

Chapter 493 (Senate Bill 1102)

This bill amends § 38.2-514.2 by allowing a motor vehicle rental contract "enroller" to solicit, negotiate, procure, or effect insurance as long as the written disclosure required by this section is provided to the prospective renter. Section 38.2-1800 has been amended to define a "motor vehicle rental contract enroller" as an unlicensed hourly or salaried employee of a motor vehicle rental company that receives no direct or indirect commission from the insurer, renter, or the vehicle rental company. The term "motor vehicle rental contract insurance agent" has been amended to clarify that it does not include the term "enroller."

Chapter 514 (House Bill 1465)

This bill amends § 38.2-2231 by allowing parties upon agreement to try their cases involving disputed auto physical damage claims in a court of competent jurisdiction as an alternative to arbitrating according to the Nationwide Intercompany Arbitration Agreement, or any successor thereto. The bill also stipulates that if an insurer cannot show proof of its membership in the Nationwide Intercompany Arbitration Agreement, or any successor thereto, an action may be asserted in a court of competent jurisdiction.

Chapter 647 (Senate Bill 1278)

This bill adds a new chapter to Title 6.1 (Banking and Finance Code) called the Real Estate Agent Registration Act. The purpose of the bill is to require "lay real estate settlement agents" performing settlement services to comply with the qualification and financial responsibility requirements of the Consumer Real Estate Settlement Protection Act (CRESPA). A "lay real estate settlement agent" is defined as a person who is not licensed as an attorney; is not a party to the real estate transaction; provides escrow, closing, or settlement services; and is listed as the settlement agent on the settlement statement.

Chapter 711 (Senate Bill 1230)

Effective 8-1-99

This bill amends § 8.01-581.15 (Civil Remedies and Procedure Code) by raising the cap on medical malpractice recoveries to $1.5 million. The law applies to acts of malpractice occurring on or after August 1, 1999. The cap increases by $50,000 on July 1 of each year except that it increases by $75,000 in 2007 and 2008. The increase in 2008 is the final increase. The increase each year applies to acts of malpractice occurring on or after the effective date of the increase.

Chapter 806 (Senate Bill 1018)

This bill amends Chapter 50 of Title 38.2 (Virginia Birth-Related Neurological Injury Compensation Fund) by allowing a legal representative of a child born between January 1, 1988 and July 1, 1990 to file a claim under Chapter 50 by July 1, 2000 if the infant would have met the definition of "birth-related neurological injury" as that term was defined in 1990. (The definition was broadened in 1990.) The claim is required to have been previously filed and dismissed because it did not meet the definition.

Chapter 822 (House Bill 1555)

This bill adds a new section to Title 8.01 (Civil Remedies and Procedure Code) and amends § 38.2-5003 by requiring the Workers' Compensation Commission to set a matter for hearing when a civil action has been referred to it by a circuit court to determine whether the cause of action satisfies the requirements of the Virginia Birth-Related Neurological Injury Compensation Act. Section 8.01-273.1 makes it clear that, when a cause of action has been referred to the Workers' Compensation Commission, the court must stay all proceedings pending an award and notification by the Workers' Compensation Commission.

Chapter 823 (House Bill 1556)

This bill amends § 38.2-5009 by requiring that the provisions of § 65.2-531 of the Code of Virginia apply to any benefits awarded for loss of earnings under the Virginia Birth-Related Neurological Injury Compensation Act. Section 65.2-531 prohibits claims from being assignable.

Chapter 824 (House Bill 1557)

This bill amends § 38.2-5016 by staggering the terms of the board members of the Virginia Birth-Related Neurological Injury Compensation Program. The bill also changes the number of directors required for a quorum from five to four directors.

Chapter 825 (House Bill 1558)

This bill adds a new section numbered § 38.2-5004.1 which requires insurance companies licensed in Virginia and self-insurers to file a report with the Virginia Birth-Related Neurological Injury Compensation Program whenever a claim is made that alleges a possible birth-related neurological injury. The report is to be completed on a form provided by the program. The program will then be required to inform the parents or guardians of the program's existence and eligibility requirements. The report is not admissible in any court and is not an inference of liability.

Chapter 826 (House Bill 1559)

This bill amends § 38.2-5015 by clarifying that the assets of the Virginia Birth-Related Neurological Injury Compensation Fund are trust funds and may be used solely to award recipients and to administer the program.

Chapter 918 (House Bill 2292)

This bill amends § 38.2-2232 by requiring insurers to offer limits of liability for uninsured private pleasure watercraft coverage equal to the liability limits of the private pleasure watercraft policy. However, no insurer is required to pay damages for uninsured private pleasure watercraft coverage in excess of the limits of uninsured private pleasure watercraft coverage provided by the policy. The optional uninsured coverage must include coverage for bodily injury and property damage liability, but a provision has been added stating that such property damage liability coverage is excess over any other valid and collectible insurance. The bill has also been amended to clarify that the provision only applies to stand-alone marine policies, and a new subsection has been added pertaining to service of process and subrogation.

Chapter 992 (House Bill 1901)

This bill amends § 38.2-2206 (dealing with uninsured motorist) by stating that the bringing of an action against John Doe tolls the statute of limitations for purposes of bringing an action against the actual owner or operator that caused the injury or damages until that person's identity becomes known. An action against the actual owner or operator may not be brought more than three years after bringing an action against John Doe.

YEAR 2000 COMPLIANCE

Chapter 17 (House Bill 1663)

This bill adds a general civil procedure law at § 8.01-418.3 to provide that Year 2000 (Y2K) assessments and documents shall not be discoverable or admissible in evidence unless a court orders discovery or admissibility following an in camera review and a showing of good cause.

Chapter 859 (House Bill 1671)

This bill enacts a public (non-codified) law that provides immunity from liability for damages to any person for injury resulting from disclosing information, in good faith, about a "Year 2000 problem" or "Y2K failure" affecting computer systems and programs. The statute does not, however, limit liability in court for those persons who disclose Y2K information for profit or disclose information, which, under conditions specified in the statute, is material and false, inaccurate or misleading.

COMPANY TAXATION BILLS

Chapter 571 (Senate Bill 908)

This bill amends subsection B of § 58.1-2526 (Taxation Code) to give the Commission specific authority to refund excess regulatory costs paid pursuant to § 38.2-1026.

FINANCIAL REGULATION BILLS

Chapter 20 (Senate Bill 901)

This bill makes several amendments to § 38.2-5802 regarding the Bureau's oversight of managed care health insurance plans (MCHIPs). This bill clarifies for the MCHIPs when each of the filing requirements enacted in 1998 Senate Bill 712 becomes applicable to the MCHIPs. Each subsection in § 38.2-5802 contains filing requirements, which become applicable for health carriers at different stages during the licensing and certification processes. This bill simply clarifies these filing requirements for all that read the statute.

Chapter 61 (Senate Bill 909)

This bill amends § 38.2-2811 to authorize the Commission to make or direct an examination of a medical malpractice joint underwriting association at least once in every five years and in accordance with examination provisions comprising Article 4 of Chapter 13 of Title 38.2. The existing statute required examinations at a greater frequency than necessary. This amendment updates the medical malpractice joint underwriting association statute by incorporating provisions that guide the financial examinations of other licensees. The proposed provisions will authorize an examination whenever the Commission considers it expedient for the protection of the interests of the people of this Commonwealth, and will require examination at least once every five years rather than each year.

Chapter 331 (House Bill 2708)

This bill adds § 6.1-2.9:8 (Banking and Finance Code) to the Code of Virginia to authorize banks, savings institutions and credit unions to act as trustees or custodians of the medical savings accounts authorized by federal law. The bank, savings institution or credit union is required to administer medical savings accounts in accordance with federal law. The bill also directs the Joint Commission on Health Care, with the assistance of the Bureau of Insurance and the Department of Taxation, to examine the current provisions of federal and state taxation and insurance laws to determine the feasibility of licensing group self-insurance associations that will pool their liabilities for the purpose of offering high-deductible, catastrophic health insurance coverage to holders of medical savings accounts. This study shall be completed prior to the 2000 Session of the Virginia General Assembly.

Chapter 482 (Senate Bill 894)

This bill amends §§ 38.2-4307 and 38.2-4307.1. The bill provides that annual statements, supplemental schedules and other forms filed by health maintenance organizations (HMOs), whether prepared on an annual or quarterly basis, should be, as far as practicable, the same as other forms in general use in the United States and prepared in accordance with appropriate instructions and publications adopted by the National Association of Insurance Commissioners (NAIC). A new subsection E in § 38.2-4307 authorizes the Commission to require all such filings be in machine-readable format and on the form blank prepared by the National Association of Insurance Commissioners (NAIC). A new subsection F in § 38.2-4307 authorizes the Commission to require HMOs to file copies of their annual statements with the NAIC. A new subsection B in § 38.2-4307.1 authorizes the Commission to require HMOs to file their statements with the NAIC on a quarterly basis.

INSURANCE AGENTS AND CONTINUING EDUCATION BILLS

Chapter 2 (House Bill 1274)

This bill adds a new section numbered § 38.2-1812.2. The bill allows an agent to charge fees for services as long as the applicant or policyholder consents in writing before the services are rendered and a schedule of fees is maintained in the agent's office. The consent form must include the applicant's or policyholder's signature, the duration of the services, the amount of fees to be charged, the services for which the fees will be charged, and a statement that the agent is also entitled to receive a commission. The provision applies to new and renewal policies issued or renewed on or after July 1, 1999.

Chapter 44 (Senate Bill 900)

This bill amends §§ 38.2-1840, 38.2-1841, 38.2-1847, 38.2-1859, 38.2-4802 and 38.2-4803 to conform all relevant portions of Title 38.2 to indicate that license application and renewal fees are nonrefundable application processing fees.

Chapter 59 (Senate Bill 892)

This bill amends §§ 38.2-1826, 38.2-1842, 38.2-1856, 38.2-1864, and 38.2-5703, and adds a new § 38.2-4803.1. All of these changes and additions are to require licensed agents, consultants, reinsurance intermediaries, managing general agents, surplus lines brokers and viatical settlement brokers to report within 30 days to the Commission the facts and circumstances regarding any felony conviction.

Chapter 86 (House Bill 1543)

This bill amends §§ 38.2-1800, 38.2-1815, 38.2-1816, 38.2-1817, 38.2-1824, 38.2-1866, 38.2-4224 and 38.2-4313. It eliminates the "Health Agent" license type, along with the pre-licensing study course and examination requirements and the continuing education requirements for that license type.

In § 38.2-1824, the bill provides that no new licenses will be issued and no existing licenses will be reinstated beginning July 1, 1999. However, those holding an

active Health Agent license on July 1, 1999 will be permitted to keep the license for a period of one year, during which time the licensee will be required to satisfy the requirements for obtaining a full Life and Health Agent license. All Health Agent licenses still in effect on June 30, 2000 will be administratively terminated.

The amendment to § 38.2-1866, eliminating the Health Agent license from the license types subject to continuing education requirements, has a delayed effective date of January 1, 2000. Such licenses, then, will be exempt from continuing education requirements for the biennium beginning January 1, 1999, as they will no longer be in effect by the end of that biennium on December 31, 2000.

Chapter 97 (House Bill 2222)

This bill amends § 38.2-1812 by adding a provision allowing insurance agents to receive commissions or other valuable consideration in their trade name as long as the trade name has been properly filed with the Bureau of Insurance pursuant to § 38.2-1822 E.

Chapter 490 (Senate Bill 984)

This bill amends §§ 38.2-1800, 38.2-1814, and 38.2-1824 by eliminating the limited license for bail bond agents. Those wishing to sell such coverage on or after July 1, 1999 must obtain a full Property and Casualty Agent license. However, bail bond agents and agencies that currently hold the limited license (as of July 1, 1999) are grandfathered.

Chapter 493 (Senate Bill 1102)

This bill amends § 38.2-514.2 by allowing a motor vehicle rental contract "enroller" to solicit, negotiate, procure, or effect insurance as long as the written disclosure required by this section is provided to the prospective renter. Section 38.2-1800 has been amended to define a "motor vehicle rental contract enroller" as an unlicensed hourly or salaried employee of a motor vehicle rental company that receives no direct or indirect commission from the insurer, renter, or the vehicle rental company. The term "motor vehicle rental contract insurance agent" has been amended to clarify that it does not include the term "enroller."

LIFE AND HEALTH BILLS

Chapter 35 (Senate Bill 244)

This bill adds § 38.2-3418.8 and amends Chapter 43 of Title 38.2 to make § 38.2-3418.8 applicable to health maintenance organizations (HMOs). The bill requires each insurer proposing to issue an individual or group hospital, medical or major medical subscription contract, and each HMO providing a health care plan for health care services to provide coverage for diabetes. The bill applies to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended on or after July 1, 1999, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

Coverage under this bill must include benefits for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. To qualify for coverage under this new law, diabetes outpatient self-management training and education must be provided by a certified, registered or licensed health care professional.

Carriers are prohibited from imposing upon any person receiving benefits pursuant to this new law any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category.

The provisions of this bill do not apply to short-term travel, accident only, limited or specified disease policies, or individual conversion policies or contracts, policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, or any other similar coverage under state or federal governmental plans.

Chapter 116 (House Bill 1769)

This bill amends § 38.2-3540.1 to revise the requirement that an insurer provide a record of the claims incurred under a group policy. The bill reduces the time that the record must be made available to the policyholder from 60 days prior to renewal (or other times when the premium or policy may be changed), to 30 days prior to renewal.

The bill applies to policies, contracts and plans delivered, issued for delivery, reissued or extended on and after July 1, 1999 or when, after the bill is effective, any term of the policy, contract or plan is changed or the premium is adjusted.

Chapter 276 (House Bill 1936)

This bill amends § 38.2-3542, dealing with notice to employees upon termination of group health insurance coverage.

- Subsection A is amended to make the requirements applicable not only to employers who are paying all or part of the premium, but also where the employer is taking responsibility for payroll deducting and remitting the premium to the insurer. The subsection is further amended to clarify that the notice requirement applies not only where the employer receives notice of termination from an insurer, but also where the plan being terminated is a self-insured plan.
- Subsection B is amended to provide that the employer who collects from employees or covers any part of the cost of coverage and who knowingly fails to remit to the insurer or plan such funds required to maintain coverage in accordance with the policy or contract provisions shall not only be guilty of a Class I misdemeanor, but shall also be subject to civil suit for any medical expenses the employee may become liable for as a result of the employer letting such coverage be terminated.
- A new Subsection C is created to prohibit retroactive termination. If the coverage terminates due to nonpayment of premium by the employer, the carrier is prohibited from terminating a covered individual's coverage unless and until the employer has been provided with a written or printed notice of termination, including a specific date, not less than fifteen days from the date of such notice, by which coverage will terminate if the overdue premium is not paid. Coverage shall not be permitted to terminate for at least fifteen days after such notice has been mailed, and each carrier is required to make reimbursement on all valid claims for services incurred prior to the date coverage is terminated.

Chapter 298 (House Bill 1546)

This bill amends § 58.1-322 (Taxation Code) to add an exclusion from Virginia taxable income for long term health care insurance for tax years beginning January 1, 2000 and thereafter. The exclusion applies "provided that the individual has not claimed a deduction for federal income tax purposes."

Chapter 321 (House Bill 2345)

This bill creates new Code § 38.2-3407.3:1 and requires carriers, when accepting premium payments in arrears, to credit such payments first to the longest outstanding arrearage, and then in succession to the most recent arrearage or payment due.

Chapter 586 (House Bill 721)

This bill amends §§ 38.2-233, 38.2-1800, 38.2-1814, 38.2-1822, 38.2-1824, 38.2-3725, 38.2-3735 and 38.2-3737 to provide that disclosures required by the above referenced sections may be combined with other disclosure statements required by federal or state law to avoid redundancy.

The bill changes the phrase "each plan of insurance" to "the insurance coverage" in §§ 38.2-233 and 38.2-3737. The term "credit property agent" is revised to "credit property and involuntary unemployment insurance agent."

The bill adds an exemption from license requirements for a person who enrolls individuals under group plans as part of his or her employment responsibilities but receives no commission or other valuable consideration for the enrollments. In addition, the compensation should in no manner be contingent on the number of individuals enrolled or the amount of premium from the enrollments. The bill defines the term "enrolling individuals" as meaning, for the subsection, “the process of informing individuals of the availability of coverages, calculating the insurance charge, assisting with completion of the enrollment application, preparing and delivering the certificate of insurance, answering questions regarding the coverages, and assisting the individual in making an informed decision whether or not enrollment under the group plan is elected.”

The bill also adds language to subsection F of § 38.2-3725 listing some of the factors that the Commission may consider when determining a fair return to insurers to assure the availability of credit insurance. The bill also adds creditor’s representative to the signatures required on an application or enrollment form.

Chapter 649/643 (House Bill 871/Senate Bill 1235)

This bill contains a number of sweeping managed care changes. It combines parts of 14 separate bills that had been introduced during the 1999 Session of the Virginia General Assembly. The bill also includes a number of provisions applicable to the state employee benefits plan, but these are not summarized below.

1. The bill adds in § 32.1-137.6 (Health Code) a requirement for managed care health insurance plans’ (MCHIPs) complaint systems. The complaint forms and written procedures to be given to covered persons must include a clear and understandable description of the covered person’s right to appeal denials of

adverse determinations and the procedure for making an appeal pursuant to § 32.1-137.15. The forms must include the phone number for the managed care licensee and the mailing address, phone number and e-mail address of the Managed Care Ombudsman (Ombudsman). A copy of an annual complaint report for each MCHIP must be submitted to the Ombudsman.

2. The bill also provides in § 32.1-137.15 that if any appeal is denied, the notification of the denial must include a clear and understandable notice of the appealing party's right to seek review of the denial according to § 38.2-5900, the procedures for obtaining the review, and the binding nature of the appeal. The notification must also include the addresses and phone numbers for the Ombudsman.

3. The bill adds § 38.2-3407.9:01 and amends § 38.2-4219 (health services plans) and § 38.2-4319 (HMOs). The section applies to insurers 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; corporations providing individual or group subscription contracts; and HMOs providing health care plans that include coverage for prescription drugs on an outpatient basis. The bill allows any such policy, contract or plan to apply a formulary to prescription drug benefits if the formulary is developed in accordance with provisions in the bill.

   If an insurer, corporation or HMO maintains one or more drug formularies, each insurer, corporation or HMO must:

   - make available to participating providers and pharmacists and to nonpreferred or nonparticipating providers the complete drug formulary or formularies, including a list of the drugs on the formulary by major therapeutic category that specifies whether a drug is preferred over other drugs; and
   - establish and maintain a process that allows an enrollee to obtain, without additional cost-sharing beyond that for formulary drugs, coverage for a specific, medically necessary nonformulary prescription drug if the formulary drug is determined by the insurer, corporation, or HMO, after reasonable investigation and consultation with the physician, to be inappropriate. The insurer, corporation or HMO has one business day to act on requests.

4. The bill amends § 38.2-3407.10 and increases the number of days that an enrollee can request to continue receiving health care from a primary care provider (PCP) being terminated to 90 days from the current 60 days. The notice that a provider must receive prior to being terminated is also increased to 90 days from the current 60 days. (Effective for contracts issued or renewed after July 1, 1999.)

   The section also permits a provider to continue rendering health services to an enrollee who has entered the second trimester of pregnancy at the time of the provider's termination except when a provider is terminated for cause. The enrollee has the option to continue the care through to post-partum care after delivery.

The section permits a provider to continue providing services to an enrollee who is determined to be terminally ill, as defined in § 1861 (dd) (3) (A) of the Social Security Act, at the time the provider is terminated except when a provider is terminated for cause. The enrollee has the option of continuing the treatment for the terminal illness for the remainder of his or her life.

These provisions apply to contracts entered into or renewed after July 1, 1999.

5. A new subsection L is added to § 38.2-3407.10 to require carriers that require preauthorization before rendering medical treatment to have personnel available to approve such preauthorization at all times.

6. A new subsection M is added to § 38.2-3407.10 to require carriers to provide to group policyholders written notice of at least 60 days before any new benefit reductions are effective. The group policyholders must provide 30 days' notice to enrollees.

7. Subsection P of § 38.2-3407.10 (formerly subsection M prior to renumbering) is amended. Contracts between providers and carriers must not include provisions pursuant to which a provider or group of providers must deny covered services that the provider or group of providers knows are medically necessary and appropriate that are provided to an enrollee or group of enrollees with similar conditions. This provision also applies to Chapter 42 (health services plans) and Chapter 43 (HMOs) of Title 38.2. These requirements apply to contracts entered into or renewed after July 1, 1999.

8. The bill adds § 38.2-3407.11:1 and amends §§ 38.2-4214 (health services plans) and 38.2-4319 (HMOs). (Effective for contracts issued or renewed after July 1, 1999.) The section requires that any insurer proposing to issue individual or group accident and sickness insurance policies; corporations providing individual or group accident and sickness subscription contracts, and HMOs providing health care plans must permit any individual covered under such plan direct access, pursuant to subsection B of § 38.2-3407.11:1, to health care services from a participating specialist who is authorized to provide such services under the plan and has been selected by the individual.

   Subsection B of § 38.2-3407.11:1 requires that an insurer, corporation or HMO, providing health insurance coverage, have a procedure by which a participant, beneficiary, or enrollee with an ongoing special condition may, after consultation with the PCP, receive a referral to a specialist who will be responsible for and capable of providing and coordinating the individual's primary and specialty care related to the initial specialty referral. If the care would most appropriately be coordinated by a specialist, the plan or issuer shall refer the individual to a specialist. The bill defines "special condition" as a condition or disease that is (i)

life threatening, degenerative, or disabling and (ii) requires specialized care over a prolonged period of time.

During the treatment period authorized in the referral, the specialist must be permitted to treat the individual without a further referral and may authorize referrals, procedures, tests and other medical services related to the initial referral as the PCP would be permitted to authorize. The insurer, corporation or HMO must inform subscribers about this section by written notice.

The section applies to policies, contracts and plans delivered, issued for delivery, reissued, renewed or extended or at any time when any term is changed or any premium adjustment is made. It does not apply to short-term travel or accident-only policies, or short-term nonrenewable policies of more than 6 months' duration or contracts issued to persons eligible for Medicare or similar coverage under state or federal government plans.

9. The bill adds § 38.2-3407.13 and amends § 38.2-4214 (health services plans), § 38.2-4319 (HMOs) and § 38.2-4509 (dental or optometric services plans). The section prohibits insurers 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, a corporation providing individual or group subscription contracts, a HMO providing health care plans, and a dental services plan offering or administering prepaid dental services from refusing to accept or make reimbursement pursuant to an assignment of benefits to a dentist or oral surgeon by an insured, subscriber or enrollee.

   Subsection B of § 38.2-3407.13 defines "assignment of benefits" as meaning the transfer of dental care coverage reimbursement benefits or other rights under an insurance policy, subscription contract or dental services plan by insured, subscriber, or plan enrollee. The assignment is not effective until the insurer, corporation or plan is notified in writing.

10. The bill adds § 38.2-3418.8 and amends § 38.2-4319 (HMOs). The section requires insurers proposing to issue individual or group accident and sickness policies providing hospital, medical and surgical, or major medical coverage on an expense incurred basis; corporations providing individual or group subscription contracts and HMOs providing health care plans to provide coverage for patient costs for clinical trials for treatment studies on cancer, including ovarian cancer. The section applies to policies, contracts or plans delivered, issued for delivery or renewal in the Commonwealth on and after July 1, 1999.

    The section requires that reimbursement for patient costs in clinical trials for cancer must be determined according to the same manner as reimbursement for other medical and surgical procedures. The coverage is to have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable

than for physical illness generally. The section defines the terms “cooperative group,” “FDA,” “Member,” “Multiple project assurance contract,” “NCI,” “NHI” and “patient cost” in subsection C.

Subsection D of § 38.2-3418.8 requires that coverage for clinical trials for treatment studies on cancer be provided if the treatment is being conducted in a Phase II, III or IV clinical trial. The treatment may be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.

Subsection E of § 38.2-3418.8 provides that the treatment described in subsection D § 38.2-3418.8 must be provided by a clinical trial approved by the National Cancer Institute (NCI); an NCI cooperative group or an NCI center; the FDA in the form of an investigational new drug application, the Federal Department of Veterans Affairs; or an institutional review board of an institution in Virginia that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

Section § 38.2-3418.8 provides, in subsection F, that the facility and personnel providing the treatment must be capable of doing so by virtue of their experience, training and expertise.

The coverage under § 38.2-3418.8 applies only if (1) there is no clearly superior, noninvestigational treatment alternative and (2) the available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative and (3) the member and physician or other health provider conclude the member’s participation would be appropriate pursuant to the procedures in the policy or evidence of coverage.

The section does not apply to short-term travel, accident-only, limited or specified disease policies or contracts designed for issuance to persons eligible for coverage under Medicare, or other similar coverage under state or governmental plans or to short-term nonrenewable policies of not more than six months’ duration.

11. The bill adds § 38.2-3418.9 to require coverage for laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy. The coverage is to include benefits for a minimum stay of not less than 23 hours for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy as outlined in Milliman and Robertson’s guidelines. The bill does not require a stay of the above hours when the covered person and attending physician determine a shorter stay is appropriate. The section applies to policies, contracts and plans, delivered, issued for delivery, reissued or extended on and after July 1, 1999, or any time when the term of the policy, contract or plan is changed or any premium adjustment is made. The section does not apply to short-term travel, accident only, limited or specified disease or individual conversion policies or contracts, or policies designed for person’s eligible for Medicare or similar state or federal governmental plans.

12. Section 38.2-3407.14 is enacted to require insurers issuing individual or group policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis; corporations providing individual or group subscription contracts; and HMOs to provide prior written notice of intent to increase an annual premium by more than 35% for renewal. The notice must be at least 60 days prior to the proposed renewal of coverage.

13. Section 38.2-3407.15 is enacted to prohibit individual or group accident and sickness policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis; corporations providing individual or group subscription contracts; or HMOs from refusing to accept or make reimbursement pursuant to an assignment of benefits to a health care provider or hospital. This is provided that the provider or hospital accepts the reimbursement as payment in full and will not bill for additional payment except for any deductible, copayment or coinsurance. The section does not apply to an assignment of benefits made to a dentist or oral surgeon.

14. Section 38.2-5804 is amended to include a requirement that the address and phone number of the managed care licensee be included in forms and procedures for the complaint system. The mailing address, phone number, and e-mail address of the Managed Care Ombudsman and the forms and procedures and a clear description of the right to appeal pursuant to § 32.1-137.15 must also be included.

15. The bill creates a new Chapter 59 in Title 38.2 that requires the establishment of an independent external review of adverse utilization review decisions by utilization review (UR) entities established pursuant to § 32.1-137.7. The bill provides in §§ 38.2-5900 through 38.2-5903 that a covered person or treating health care provider may appeal to the Bureau of Insurance for review of a final adverse decision for a health service costing more than $500. The Commission may adopt regulations. The appeal must be filed within 30 days of the decision. The appeal must be on forms prescribed by the Bureau and must include a release for all pertinent medical records. There is a $50 nonrefundable filing fee. The fee will be collected by the Commission, paid into the state treasury, and credited to the fund for the maintenance of the Bureau. The Commission may waive the fee for good cause if the fee would cause financial hardship. The Bureau must provide a copy of the appeal to the UR entity that made the adverse decision.

    The Bureau or its designee must conduct a preliminary review to determine (i) if the applicant is a covered person or treating health care provider with the consent of the covered person (ii) whether the benefit or services reasonably appears to be a covered service costing more than $500, (iii) whether all complaint and appeal procedures available under Article 1.2 of Chapter 5 (§ 32.1-137.7 et seq.) of Title 32.1 (Health Code) have been exhausted and (iv) whether the application is otherwise complete and correctly filed. The review must be conducted within 5

working days of receipt of all information and documentation necessary. The Bureau must not accept any application that fails to meet the requirements set forth in subsection B of § 38.2-5901. The Bureau or its designee must notify the applicant and UR entity within 3 working days of the completion of the preliminary review whether or not the appeal is accepted.

The covered person, treating provider and UR entity must provide copies of relevant medical records within 10 working days of when notice of the acceptance of an appeal is mailed. The confidentiality of the medical records is to be maintained according to Virginia laws. The Bureau or its designee may request additional medical records. If the request for additional information is not supplied within 10 working days, the appeal may be dismissed or the final decision reversed at the Commissioner's discretion. The Commissioner may for good cause provide an extension of time for the covered person, provider, UR entity, and the Commission.

The Bureau is required to contract with one or more impartial health entities for the purpose of performing the review of final adverse decisions. The Commission must adopt regulations to assure that the entity has adequate standards, credentials and experience. The impartial health entity shall examine the decision to determine if it is objective clinically valid, compatible with established principles of health care and appropriate in light of the contractual obligations to the covered person. The entity must review the appeal; the response of the UR entity; any affidavits the covered person, treating provider or UR entity file with the Bureau of Insurance; and any medical records the impartial entity deems appropriate. Prior to assigning an appeal to an impartial health entity, the Bureau shall verify that the impartial health entity is not affiliated with or a subsidiary of or owned or controlled by a health plan, trade association of health plans or a professional association of health care providers.

The impartial health entity is to issue written recommendations on the final adverse decision within 30 working days. The Commissioner of Insurance, based on the recommendation, must issue a written notice affirming, modifying or reversing the final decision. The ruling is not to be construed as a final finding, order or judgment of the Commission and is exempt from the Administrative Process Act. The Commissioner's ruling must carry out the recommendations of the entity unless the entity exceeded its authority or acted arbitrarily or capriciously. The written ruling will bind the covered person and the policy or contract issuer to the extent to which each would have been obligated by a judgment entered in an action at law or in equity with respect to the issues.

The Bureau of Insurance is to contract with one or more impartial health entities such as medical peer review organizations and independent UR companies. The Bureau must verify before assignment that the impartial health entity has no relationship or association with (i) the UR entity; (ii) the covered person; (iii) the treating health care provider; (iv) the medical care facility where the service would

be provided; or (v) the development or manufacture of the drug device, procedure or other therapy that is the subject of the review.

There is no liability on the part of and no cause of action shall arise against any officer or employee of an impartial health entity for actions or statements made in good faith performance or their powers and duties.

A new subsection D in § 38.2-5902 is added to require any MCHIP that must provide previously denied services will be subject to payment of fees the Commission deems appropriate to cover the review costs.

Each insurer writing insurance defined as § 38.2-109, HMO, and nonstock corporation organized according to Chapter 42 (38.2-4200 et seq.) or Chapter 45 (38.2-4500 et seq.) must pay an assessment of an amount not to exceed 0.015 percent of the direct gross premium income during the preceding calendar year. The assessment must be apportioned, assessed and paid according to § 38.2-403. The assessment made and paid into the state treasury shall be deposited in a special fund designated "Bureau of Insurance Special Fund-State Corporation Commission." Money for necessary regulation, supervision and examination of regulated entities shall be appropriated from the fund.

The bill also creates, in §§ 38.2-5904 and 38.2-5905, the Office of Managed Care Ombudsman (Ombudsman) within the Bureau of Insurance. The Ombudsman shall promote and protect the interests of covered persons under managed health insurance plans. All state agencies must assist the Ombudsman in the performance of his duties.

The Ombudsman shall assist covered persons in understanding their rights and the processes available to them; answer inquiries from citizens by phone, e-mail, and in person; provide information on MCHIPs and other UR entities upon request; develop information on types of managed health insurance plans available, including mandated benefits and UR procedures and appeals; make available separately or through the existing Internet website for Bureau of Insurance, information on plans; maintain data on complaints and inquiries received, type of assistance requested, action taken and disposition; when requested, assist persons in using procedures and processes available to them, including UR appeals; ensure covered persons timely responses to inquiries and access to services of the Office of the Ombudsman; provide assessments of proposed and existing MCHIP laws and studies of other MCHIP issues upon request of the committees of the General Assembly or Joint Commission on Health Care (JCHC); monitor changes in federal and state laws; report annually to the appropriate committees of the General Assembly and the JCHC by December 1 of each year. The Ombudsman must report on activities of the Office and a summary of significant developments in federal and state laws; and conduct other activities the Commission considers appropriate. A person's written consent must be obtained to review medical

records. Medical records must be maintained according to the confidentiality laws of Virginia.

The Commission shall promulgate regulations for the chapter, including provisions for expedited appeals for emergency care; and standards, credentials and qualifications for impartial health entities.

The second enactment clause in the bill requires the SCC to promulgate regulations for Chapter 59 (Independent Review and the Ombudsman) within 280 days of enactment of the bill. The third enactment clause provides that the bill is effective on July 1, 1999, but the appeals processes in Chapter 59 are effective the earlier of 90 days after the regulations are promulgated or July 1, 2000.

16. The provisions of §§ 38.2-3407.15 and its application to Chapters 42 (health services plans), 43 (HMOs) and 45 (dental or optometric services plans), are effective only if passed by the 2000 General Assembly. The Joint Commission on Health Care shall consult with the Bureau of Insurance and shall review the financial impact of the changes on health care costs, health insurance premiums and the availability of health care in Virginia.

Chapter 709/739 (Senate Bill 1176/House Bill 2213)

This bill amends §§ 38.2-510, 38.2-4214, 38.2-4319 and 38.2-4509 (to make these provisions applicable to health services plans, HMOs, and dental or optometric plans), and adds § 38.2-3407.13 relating to health insurance and fair business practices.

Section 38.2-510 A, which lists the practices that will be considered unfair claim settlement practices if performed with such frequency as to indicate a general business practice, is amended adding subsection 15. Subsection 15 provides that failure to comply with § 38.2-3407.13 or to perform any provider contract provisions pursuant to that section will be considered an unfair claim settlement practice.

Section 38.2-3407.13 is added which provides for ethics and fairness in carrier business practices.

Section 38.2-3407.13 A provides definitions for “carrier,” “enrollee,” “provider,” “claim,” “clean claim,” “health care services,” “health plan,” “provider contract,” “retroactive denial of a previously paid claim,” and “retroactive denial of payment.” The definition of “claim” does not include a request for payment as an acceptable form of loss to be presented to a carrier.

Section 38.2-3407.13 B requires that every provider contract entered into by a carrier shall contain specific provisions requiring the carrier to adhere to or comply with certain minimum fair business standards in the processing and payment of claims. Subsection B lists these minimum fair business standards.

- Subdivision B 1 requires that a carrier pay any claim within “forty” days of receipt of the claim.

- Subdivision B 1 b requires a carrier to maintain a written or “electronic” record of the date of receipt of a claim.

- Subdivision B 2 requires that carriers must request additional information from the person submitting the claim within “thirty” days after receipt of a claim. Additional language also emphasizes that the subsection does not require a carrier to pay a claim that is not a clean claim.

- Subdivision B 3 allows a carrier up to sixty days after a claim is paid to pay the interest owing on the claim.

- Subdivision B 4 a requires that a carrier establish reasonable policies allowing providers to confirm in advance, by telephone or “electronic means” if available, whether a service would be considered a medically necessary covered benefit and other carrier requirements.

- Subdivision B 4 b requires carriers to make available to providers access to all policies applicable to the provider within “ten” business days of receipt of a request for such information.

- Subdivision B 5 requires carriers to pay claims when the carrier has previously authorized the health care services or advised the provider or enrollee prior to the provision of such services that they are medically necessary and a covered benefit, except for certain circumstances listed in subdivisions 5 a and 5 b. Subdivision 5 b adds an exclusion in which the person receiving services was not eligible on the date of service and the carrier did not know of the person’s eligibility status.

- Subdivision B 6 prohibits a carrier from imposing retroactive denials on previously paid claims unless the carrier has provided at least thirty days prior written notice to the person submitting the claim, stating the reasons for the denial. This requirement is to become effective July 1, 2000. In addition, one of several other factors must apply, including that the time the original claim was paid has not exceeded 12 months, or that the number of days required by the carrier in its provider contract that a claim be submitted following the date the health care service was provided.

- Subdivision B 8 requires that carriers submit to providers any changes to the provider contract at least 90 days in advance of the effective date. Subdivision B 9 allows carriers to comply with subdivisions B 7 and B 8 by providing a clear, written explanation of the policy.

Section 38.2-3407.13 C provides that the Commission shall have the jurisdiction to determine (1) if a carrier has violated subsection B of § 38.2-3407.13 by failing to include the requisite provisions in its provider contracts, and (2) if the carrier has failed to implement the minimum fair business standards pursuant to subdivisions B 1 and B 2.

Section 38.2-3407.13 D provides that no carrier shall be in violation of this section if failure to comply is caused in material part by the person submitting the claim, or if the carrier's noncompliance is the result of matters beyond the carrier's reasonable control which are not caused in material part by the carrier.

Section 38.2-3407.13 E provides that any provider who suffers damage as a result of a carrier's violation of this section or breach of any provider contract provision required by this section will be entitled to initiate an action to recover actual damages, and may be awarded reasonable attorney's fees and court costs. Damages awarded may be increased by three times the actual damages if it is determined that the violation or breach was a result of gross negligence and willful conduct. The Commission is not to be deemed "a trier of fact."

Section 38.2-3407.13 F provides that no carrier shall terminate or fail to renew a provider contract, or penalize a provider for invoking the provider's rights under this section or the provider contract.

Section 38.2-3407.13 G provides that this section shall apply to all carriers subject to regulation under Title 38.2.

Section 38.2-3407.13 H provides that this section shall apply to provider contracts entered into, amended, extended or renewed on or after July 1, 1999.

Section 38.2-3407.13 I cites § 38.2-223 as granting the Commission authority to promulgate regulations to implement this section.

Section 38.2-3407.13 J states severability provisions.

Section 38.2-3407.13 K states that the Commission shall have no jurisdiction to adjudicate individual controversies relating to this section.

Sections 38.2-4214, 38.2-4319 and 38.2-4509 are revised to make this bill applicable to health services plans, HMOs and dental or optometric plans.

Chapter 789/815 (House Bill 2463/ Senate Bill 1217)

This bill revises § 38.2-3431 in Article 5 (Group Market Reforms and Individual Coverage Offered to Employees of Small Employers) of Chapter 34 of Title 38.2 dealing with accident and sickness insurance. The bill revises subsection A 3 of § 38.2-3431 to remove individual coverage of employees of a small employer from the requirement of the article if the only criterion met in the subsection is that payroll deduction is permitted by the employer for the policy premium. The bill provides that the article applies if the employer has paid any portion of the premium and payroll deduction is allowed provided that the issuer providing the coverage is registered as a small group carrier and has offered small group coverage to the employer as required by the article.

Chapter 856 (Senate Bill 1299)

This bill amends §§ 38.2-4214 (health services plans) and 38.2-4319 (HMOs), and adds § 38.2-3407.11:1 relating to standing referral for cancer pain management.

Section 38.2-3407.11:1 A requires that any insurer proposing to issue individual or group accident and sickness insurance policies; any corporation providing individual or group accident and sickness subscription contracts; and any HMO providing health care plans shall permit any individual covered under such plan who has been diagnosed with cancer to have a standing referral to a board-certified physician in pain management or oncologist.

Section 38.2-3407.11:1 B provides that a board-certified physician in pain management or oncologist shall be required to consult on a regular basis with the patient's primary care physician and oncologist regarding the plan of pain management for the patient. The board-certified physician in pain management or oncologist is not authorized to direct the patient to other services.

Section 38.2-3407.11:1 C allows an insurer, corporation or HMO to require that a board-certified physician in pain management or oncologist provide written notification to the patient's primary care physician of any visit to him.

Section 38.2-3407.11:1 D provides that each insurer, corporation or HMO subject to the provisions of this section are required to inform subscribers, in writing, within the policy or evidence of coverage, of the provisions of this section.

Section 38.2-3407.11:1 E provides that the requirements of this bill shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, renewed, or extended or when any term is changed or any premium adjustment is made. This section does not apply to short-term travel or accident-only policies, to

short-term nonrenewable policies of not more than six months' duration, or policies or contracts issued to persons eligible for Medicare, or any other similar coverage under state or federal governmental plans.

Sections 38.2-4214 and 38.2-4319 are revised to make this bill applicable to health services plans and HMOs.

Chapter 857 (Senate Bill 1300)

This bill amends §§ 32.1-137.7, 32.1-137.10, 32.1-137.13, and 32.1-137.15 (Health) and §§ 38.2-4214 (health services plan) and 38.2-4319 (HMOs). The bill revises the definition of "adverse decision" in § 32.1-137.7 to include a requirement that when a policy, contract, plan, certificate or evidence of coverage includes coverage for prescription drugs, any adverse decision for a prescription for alleviating cancer pain must be made within 24 hours of the request for coverage.

The bill requires that the specific procedures for review determinations include an expedited review of no more than 24 hours for prescriptions for alleviating cancer pain. Treating providers are to be notified orally by phone within 24 hours of any adverse decision for drugs to alleviate cancer pain. A physician advisor is to review the issue of medical necessity with the provider if there is any adverse decision for prescriptions for cancer pain.

An expedited appeal process of no more than 24 hours is to be established for final appeals for adverse decisions for prescriptions for cancer pain. The treating physician is to have an opportunity for immediate appeal by phone when there is an adverse decision. An expedited appeal may be requested when a regular reconsideration would subject a cancer patient to pain.

Section 38.2-3407.6:1 applies to insurers issuing individual or group accident and sickness policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis; corporations providing individual or group subscription contracts, or HMOs providing health care plans that issue policies, contracts or plans, including coverage for prescription drugs, on an inpatient or outpatient basis. The policies, contracts or plans must provide that benefits will not be denied for payment for any drug approved by the U.S. Food and Drug Administration for use in the treatment of cancer pain on the basis that the dosage is in excess of the recommended dosage if the prescription has been prescribed in compliance with §§ 54.1-2971.01, 54.1-3303 and 54.1-3408.1 (Professions and Occupations) for a patient with intractable cancer pain.

The bill does not apply to short-term travel, accident-only, or short-term nonrenewable policies of not more than 6 months' duration. The provisions of the bill apply to contracts, policies or plans delivered, issued for delivery or renewed on or after July 1, 1999.

Chapter 858 (House Bill 699)

This bill adds § 38.2-3418.8. The bill applies to insurers issuing individual and group accident and sickness policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis; corporations issuing individual or group subscription contracts; and HMOs providing health care plans for health care services. The bill requires the contracts to include coverage for hospice services. The provisions apply to policies, contracts or plans delivered, issued for delivery or renewed on or after July 1, 1999.

The bill defines the terms "hospice services," "individuals with a terminal illness," "palliative care" and "Medicare." The bill also provides that documentation requirements shall not be greater than those required for Medicare.

The bill does not apply to policies for short-term travel, accident only, short-term non-renewable contracts for not more than six months' duration, or policies designed for those eligible for Medicare. Insurers and HMOs are not prohibited from offering or providing hospice services if an illness is not terminal or life expectancy is longer than 6 months.

Chapter 921 (House Bill 2354)

This bill amends § 38.2-3418.1:2 in the mandated benefits article (Article 2 of Chapter 34 of Title 38.2) and § 2.1-20.1 (Administration of Government Code) dealing with the health coverage requirements for state employees. The bill revises the current mandate that requires that individual or group accident and sickness policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis; corporations providing subscription contracts; and health maintenance organizations providing health care plans to provide coverage for annual pap smears. The bill adds a requirement for coverage on and after July 1, 1999 for annual testing performed by any FDA-approved gynecologic cytology screening technologies.

The provisions do not apply to short-term travel, accident only, limited or specified disease policies or short-term nonrenewable policies of not more than six months' duration.

Chapter 923 (House Bill 2385)

This bill adds § 38.2-3407.13 and amends §§ 38.2-4214 and 38.2-4319 to make the bill applicable to health services plans and HMOs. The bill applies to accident and sickness insurers providing hospital, medical and surgical or major medical coverage on an expense-incurred basis; corporations providing individual or group subscription contracts and HMOs providing health care plans. All policies, contracts, or plans that include coverage for obstetrical services as an inpatient in a general hospital or obstetrical services by a physician must provide those benefits with durational limits, deductibles, coinsurance factors, and copayments that are no less favorable than for physical illness generally.

The bill applies to all policies, contracts, and plans delivered, issued for delivery, reissued, renewed, or extended or at any time when any term is changed or any premium adjustment is made on and after the effective date of the bill.

The bill does not apply to short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, or policies or contracts designed for issuance to persons eligible for Medicare, or any other similar coverage under state or federal governmental plans.

Chapter 941 (Senate Bill 430)

Effective 1/1/2000

This bill adds § 38.2-3412.1:01, amends § 38.2-3412 (the existing mental health mandate provision) and § 38.2-4319 to make the requirement applicable to HMOs. The bill also amends § 38.2-3412, the existing mental health mandate provision.

The bill requires insurers 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; corporations providing individual or group subscription contracts; and HMOs providing health care plans to provide coverage for biologically-based mental illnesses. A “biologically-based mental illness” is defined as 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 illnesses 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 alcohol addiction.

The benefits for the biologically-based mental illnesses may be different from benefits for other illnesses, conditions or disorders if the benefits meet the medical criteria necessary to achieve the same outcomes achieved by the benefits for any other illness, condition or covered disorder. However, the coverage for biologically-based mental illnesses is to be neither 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, or copayment and coinsurance factors.

The bill does not preclude the undertaking of usual and customary procedures to determine the medical necessity and appropriateness of treatment provided that all medical necessity and appropriateness determinations are made in the same manner as for other illnesses, conditions, or disorders.

The bill does not apply to (i) short-term travel, accident only, limited or specified disease policies or (ii) short-term nonrenewable policies of not more than 6 months' duration or (iii) policies or contracts designed for persons eligible for Medicare or other similar coverage under state or federal plans.

The bill also amends existing § 38.2-3412.1 to provide that § 38.2-3412.1 does not apply to "biologically-based mental illnesses" as defined in § 38.2-3412.1:01 unless coverage for mental illness is not otherwise available pursuant to § 38.2-3412.1:01.

The bill has a delayed effective date of January 1, 2000, and a "sunset" provision under which the law will expire on July 1, 2004. Prior to that date, the Special Advisory Commission on Mandated Health Insurance Benefits is to conduct a study to determine the effects, if any, of the coverage required under § 38.2-3412.1:01 on claims experience for and costs of policies, contracts or plans, and is required to submit its written report not later than December 1 of 2001, 2002, and 2003.

Chapter 1004 (House Bill 2283)

This bill amends §§ 38.2-3430.2, 38.2-3430.3, 38.2-3430.8, 38.2-3431, 38.2-3432.3, and 38.2-3514.1. The bill reduces the number of months of creditable coverage required in order to meet the definition of an "eligible individual" to 12 months for the purpose of obtaining other health insurance coverage, and adds a requirement that health insurance issuers include questions on health coverage applications that will enable the health insurance issuers to determine if an applicant is an "eligible individual" as defined in § 38.2-3430.2.

In § 38.2-3430.2, the definition of "eligible individual" is amended to include individual health insurance coverage among the types of coverage that may be counted in determining prior creditable coverage, and specifies that where individual health

insurance coverage is the most recent creditable coverage, the aggregate period of creditable coverage required is reduced to 12 months.

In § 38.2-3430.3, a requirement is added that health insurance issuers include on all applications for health insurance coverage questions that will enable the health insurance issuer to determine if an applicant is applying for coverage as an "eligible individual" as defined in § 38.2-3430.2.

Section 38.2-3430.8 is amended to make subsections A through E of § 38.2-3432.3 in the group market reforms article applicable to individual coverage.

In § 38.2-3431, the definition of "creditable coverage" is amended by adding individual health insurance to the list of qualifying coverages.

Section 38.2-3432.3 is amended by making the preexisting condition provision applicable to both group and individual coverage:

- Subsection A is amended by making the existing definition and time limits (6-month lookback) applicable only to group coverage, and adding a new definition and time limit (1-year lookback) applicable to individual coverage. The section is further amended to permit the preexisting condition limitation period to extend no longer than 12 months, including for late enrollees.
- Subsection B is amended by modifying the provision prohibiting pregnancy from being treated as a preexisting condition so that where the coverage being issued is individual coverage, the health insurance issuer may impose a preexisting condition exclusion for pregnancy existing on the effective date of coverage.
- A new exception is added in Subsection B. The provision in § 38.2-3432.3 A 4 (formerly A 3) under which the exclusion period for preexisting conditions is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date will not apply to health insurance coverage offered in the individual market on a "guarantee issue" basis without regard to health status, including open enrollment policies or contracts issued pursuant to § 38.2-4216.1 and policies, contracts, certificates or evidences of coverage issued through a bona fide association or to students through school sponsored programs at a college or university unless the person is an eligible individual as defined in § 38.2-3430.2.

Section 38.2-3514.1 is amended by making that section inapplicable to all policies subject to Article 4.1 (§ 38.2-3430.1 et seq.) of Chapter 34 of Title 38.2.