

Section 1. Title 22, Chapter 65, Subchapter I of the Virgin Islands Code is amended by adding subsections 1722(g) and (h) to read as follows:

(g) “Reasonable cost” means a defined percentage above Hawaii Medicare Part B Fee Schedule used to determine reasonable costs incurred by providers in furnishing covered services to enrollees. The defined percentages above Hawaii Medicare Part B Fee Schedule are as follows:

Individual plan: 1.50 percent above Hawaii Medicare Part B Fee Schedule.

Commercial plan: 1.80 – 2.0 percent above Hawaii Medicare Part B Fee Schedule .

Government plan: 1.80 percent above Hawaii Medicare Part B Fee Schedule.

(h) “Reasonable cost basis” means the calculation to determine the reasonable cost incurred by individual providers when furnishing covered services to beneficiaries. The reasonable cost is based on the actual cost of providing such services, including direct and indirect cost of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by a health insurance program.

Section 2. Title 22, Chapter 65 of the Virgin Islands Code is amended by renumbering Subchapter II Coverage for Autism Spectrum Disorders in Health Care Plans to reflect Subchapter III and adding a new Subchapter II The Virgin Islands Healthcare Reform Act to read as follows and:

SUBCHAPTER II THE VIRGIN ISLANDS HEALTHCARE REFORM ACT

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II.I General Provisions

§ 1900. Short Title

This Act may be cited as the “Virgin Islands Healthcare Reform Act.”

§ 1901. Statement of Purpose

This Act is created to make applicable specific provisions of Federal Health Reform, implemented through the “Patient Protection and Affordable Care Act” and “Health Care and Education Reconciliation Act” to large group, small group and individual health plans in the Territory. This Act is intended to promote the availability of health insurance coverage to groups and individuals, to prevent abusive rate practices, and to require disclosure. Included in this Act are the requirements for guaranteed availability and guaranteed renewability. Included also are the regulation and management: (1) of prescription drugs, (2) of claim audit procedures and (3) of grievance procedures. It also seeks to clarify the definition of reasonable costs.

§ 1902. Definitions

For purposes of this Act, except in those chapters of Title 22, VI Code in which a more specific definition is provided, the following terms shall have the meaning stated below:

- (a) “Actuarial Value” or “AV” means the percentage paid by a health benefit plan of the total allowed costs of benefits.
- (b) “Annual open enrollment period” means the period each year during which an individual may enroll or change coverage in a health benefit plan.
- (c) “Benefit year” means a calendar year for which a health benefit plan provides coverage for health benefits.
- (d) “Covered Benefits” or “Benefits” means the healthcare services to which a covered person or enrollee is entitled under a health plan.
- (e) “Medical Care” means:
 - (1) The diagnosis, mitigation, treatment, or prevention of disease;
 - (2) Transportation primarily for and essential to medical care referred to in subparagraph (1).

- (f) “Clinical Review Criteria” means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health insurance organization or insurer to determine medical necessity and appropriateness of healthcare services.
- (g) “CMS” means the federal Centers for Medicare and Medicaid Services.
- (h) “Commissioner” means the Commissioner of Insurance.
- (i) (1) “Cost-sharing” means any expenditure required by or on behalf of an enrollee with respect to essential health benefits.
(2) “Cost-sharing” includes deductibles, coinsurance, copayments or similar charges, but excludes premiums, balance billing amounts for non-network providers and spending for non-covered services.
- (j) “Dependent” means any person who is or may be eligible for a health plan due to his/her relationship with the subscriber and in accordance with the conditions set forth in the health plan. The following may be considered dependents of the subscriber:
 - (1) The spouse;
 - (2) A birth or adopted child or child placed for adoption under age twenty-six (26);
 - (3) A birth or adopted child or child placed for adoption who, regardless of his/her age, is incapable of earning a living due to mental or physical disability existing before he/she has attained twenty-six (26) years of age, and the regulations thereunder;
 - (4) Stepchildren;
 - (5) Foster children who have lived since infancy under the same roof with the subscriber in a normal parent/child relationship and who are, and shall continue to be, totally dependent on the family of said subscriber to receive support;
 - (6) unemancipated minor whose custody has been awarded to the subscriber;
 - (7) a person of any age who has been declared incompetent by a court and whose custody has been awarded to the subscriber;
 - (8) a parent or parent-in-law of the main subscriber who permanently resided in the household of such main subscriber and is substantially dependent on him/her for support, and who may be classified in the optional or collateral dependents category, as such term is commonly accepted and defined in the health insurance market;
 - (9) a parent or parent-in-law of the main subscriber who does not reside in the household of such main subscriber, and who may be classified in the optional or collateral dependents category, as such term is commonly accepted and defined in the health insurance market.
- (k) “EHB-benchmark plan” means the standardized set of essential health benefits (EHB) that a health insurer must provide as required by the Commissioner or Secretary.
- (l) “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably expect that the absence of immediate medical attention could place an individual’s health in serious jeopardy; results in serious dysfunction of a bodily organ or part; or for a pregnant woman who is having contractions, the lack of sufficient time to transfer

- her to other facilities before delivery, or that her transfer would result in serious jeopardy to her health of her unborn child.
- (m) “Enrollee” means an eligible person or eligible employee who is enrolled in a health insurance plan. Dependents are not referred to as enrollees.
 - (n) “Healthcare Facility” or “Facility” means a licensed institution providing healthcare setting, including hospitals and other inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, radiology, and imaging centers; and rehabilitation and other therapeutic health setting.
 - (o) “HHS” means the U.S. Department of Health and Human Services.
 - (p) (1) “Health factor” means, in relation to any individual, any of the following health status-related factors:
 - (A) Health status;
 - (B) Medical condition, including both physical and mental illnesses;
 - (C) Claims experience;
 - (D) Receipt of health care services;
 - (E) Medical history;
 - (F) Genetic information;
 - (G) Evidence of insurability, including:
 - (i) Conditions arising out of acts of domestic violence; or
 - (ii) Participation in activities, such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities; or
 - (H) Disability.
 - (2) For purposes of this subsection, “health factor” does not include the decision whether to elect individual market health insurance coverage, including the time chosen to enroll, such as under special enrollment or later enrollment.
 - (q) “Minimum Essential Coverage” has the meaning stated in Section 5000A(f) of the Internal Revenue Code.
 - (r) “Health Insurance Organization” or “Insurer” means an entity, subject to the insurance laws and regulations of the Virgin Islands or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse the costs of healthcare services, including any for-profit or non-profit hospital and healthcare service corporation, healthcare services organization, or any other entity providing health benefit, service, or healthcare plans.
 - (s) “Healthcare Service Organization” means any entity that contracts to provide or arrange for healthcare services to its subscribers, based on the prepayment thereof, except for the amount to be paid by the subscriber as copayment, coinsurance, or deductible.
 - (t) “Person” means any natural or juridical person, including corporations, partnerships, associations, joint association, limited partnership, trust, unincorporated organization, and similar entities or combination thereof.
 - (u) “Covered Person” or “Enrollee” means the holder of a policy or certificate, subscriber, or other individual participating in a health benefit plan.

- (v) “Closed Plan” means a managed care plan that requires covered persons or enrollees to use only participating providers under the terms of a health plan.
- (w) “Health Plan” means a policy, contract, certificates, or agreement offered by a health insurance organization, healthcare service organization, or any other insurer provided in consideration of or in exchange for the payment of a premium, or on a prepaid basis, through which a health insurance organization, healthcare service organization, or any other insurer commits to provide coverage or pay for the costs of specified healthcare, hospital, major medical, dental, mental health, or incidental services to the rendering thereof.
 - (1) “Health Plan” shall not include:
 - (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 insurance;
 - (e) Automobile medical payment insurance;
 - (f) Credit-only insurance;
 - (g) Coverage for on-site medical clinics; or
 - (h) Other similar insurance coverage under which benefits for health services are secondary or incidental to other insurance benefits.
 - (2) “Health Plan” shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
 - (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; or
 - (c) Other similar, limited benefits.For purposes of this subsection, benefits shall not be considered an integral part of the plan, if they fail to meet the following requirements:
 - (a) Enrollees may choose not to receive coverage for such benefits, that is, the benefits provided are optional; and
 - (b) Enrollees are required to pay a premium or additional contribution for such optional benefit coverage.
 - (3) “Health Plan” shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance:
 - (a) Coverage only for a specified disease or illness;
 - (b) Hospital indemnity or other fixed indemnity insurance;
 - (c) Medicare supplemental health insurance;
 - (d) Coverage supplemental to the coverage provided (known as TRICARE supplemental programs); or
 - (e) Similar supplemental coverage provided to coverage under a group health plan.
- (x) “Indemnity Health Plan” means a health plan other than a managed care plan.

- (y) “Managed Care Plan” means:
 - (1) A health plan that requires a covered person or enrollee to use, or creates incentives, including financial incentives, for a covered person or enrollee to use healthcare providers managed, owned under contract with, or employed by the health insurance organization or insurer.
 - (2) A “Managed Care Plan” includes:
 - (a) A Preferred Provider Organization, as defined in the V.I. Code Ann. Section 1722(f) of this Title; and
 - (b) An open-ended plan, as defined in Section 1902(z) of this Act;
- (z) “Open-ended Plan” means a managed care plan that offers incentives, including economic incentives, for covered persons or enrollees to use participating providers under the terms of a health plan.
- (aa) “Product” means a discrete package of health insurance coverage benefits that a health insurer offers using a particular product network type (e.g. HMO, PPO, EPO, POS or indemnity) within a geographical service area.
- (bb) “Healthcare Professional” means a physician or other healthcare practitioner, licensed, accredited, or certified by the appropriate entities, to perform specified healthcare services consistent with the corresponding laws or regulations of the Virgin Islands.
- (cc) “Healthcare Provider” or “Provider”, as used in this Subchapter, is defined in the V.I. Code Ann. Section 1722(b) of this Title.
- (dd) “Participating Provider” or “Preferred Provider Organization”, as used in this Subchapter, is defined in the V.I. Code Ann. Section 1722(f) of this Title.
- (ee) “Reasonable cost” as used in this Subchapter, is defined in the V.I. Code Ann. Section 1722(g) of this Title.
- (ff) “Reasonable cost basis” as used in this Subchapter, is defined in the V.I. Code Ann. Section 1722(h) of this Title.
- (gg) “Health Insurance Code Regulations” refer to the rules or regulations adopted by the Commissioner pursuant to any provision of this Title.
- (hh) “Authorized Representative” means:
 - (1) a person to whom the covered person or enrollee has given express written consent to represent him/her for purposes of this Code;
 - (2) a person authorized by law to provide substituted consent for a covered person or enrollee;
 - (3) a family member of the covered person or enrollee or the healthcare professional who is treating such covered person or enrollee when he/she is unable to provide consent;
 - (4) a healthcare professional if the covered person or enrollee’s health plan requires that a request for benefits be initiated by the healthcare professional;
 - (5) For any urgent care request, a healthcare professional with knowledge of the covered person or enrollee’s medical condition.
- (ii) “Secretary” means the Secretary of Health and Human Services.

- (jj) “Service area” means the area where a health plan accepts members if it limits membership based on where people live. For plans that require you to use their doctors and hospitals, it is also the area where services are provided of routine (non-emergency) service. The plan may disenroll you if you move out of the plan’s service area.
- (kk) “Emergency Services” mean healthcare services furnished or required to treat an emergency medical condition. Health plans cannot limit emergency services to service area only or require approval before seeking emergency room services from a provider or hospital outside of the plan’s network in the United States. In the United States means anywhere in the 50 states of the United States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and Northern Mariana Islands.
- (ll) “Healthcare Services” or “medical services” mean services for the diagnosis, prevention, treatment, cure or relief of a chronic health condition, illness, injury, or disease.
- (mm) “Special enrollment period” means a period during which an individual or covered person who experiences certain qualified events may enroll in or change enrollment in a health benefit plan outside of the initial and annual open enrollment period.
- (nn) “Subscriber” means an individual covered by a health plan issued by a healthcare service organization or insurer.
- (oo) “Urgent Care” is a sudden illness that does not threaten the life or the integrity of a person, and may be treated in a physician’s office or extended hours clinic, and not necessarily in an emergency room, but if it is not properly treated at the appropriate time, may become an emergency.

§ 1903. Applicability and Scope

This Act shall apply to health insurance organizations and insurers offering health insurance plan in the group or individual market in the Virgin Islands.

§ 1904. Applicable Federal and Virgin Islands Laws

- (a) Health insurance organization or insurer offering individual health plan may establish:
 - (1) Reasonable Lifetime limits; and
 - (2) Reasonable Annual limits.
- (b) Health insurance organization or insurer offering group or individual health insurance may make available Essential Health Benefits (EHB) coverage for the following services:
 - (1) Ambulatory and medical surgical services
 - (2) Emergency services
 - (3) Hospitalization
 - (4) Maternity and newborn care
 - (5) Mental health and substance use disorder services including behavioral health treatment
 - (6) Prescription drugs
 - (7) Rehabilitative and habilitative services and devices

- (8) Laboratory, x-ray, and diagnostic testing services
 - (9) Preventative and Wellness services and chronic disease management
 - (10) Pediatric services including the respiratory syncytial virus vaccine and the cervical cancer vaccine, and oral and vision care
- (c) Nothing provided in this section shall be construed to prohibit a health insurance organization or insurer from providing EHB coverage less than those described in subparagraph (c).
 - (d) Notwithstanding the above, no group or individual health insurance plan that includes emergency services coverage shall require prior authorization for such services, whether the healthcare provider is a participating provider or not.
 - (e) Every group or individual health insurance plan that requires the designation of a primary care provider, when the enrollee is eighteen (18) years old or less, shall permit the designation of a physician who specializes in pediatrics as the child's primary care provider, provided that such provider participates in the network of participating providers of the health plan. "Primary care provider" means the participating provider designated by a health insurance organization or insurer to supervise, coordinate, or provide initial care or continuing care to the covered person or subscriber. In addition, the health insurance organization or insurer may require the primary care provider to initiate a referral for specialty care and maintain supervision of healthcare services rendered to the covered person or enrollee.
 - (f) No group or individual health insurance plan shall require prior authorization or referral to obtain obstetrical and gynecological care provided by the participating providers.
 - (g) Group health plans are still prohibited from applying a lifetime and annual dollar limits to group plans under the Employee Retirement Income Security Act (ERISA).

§1905. Powers and Duties of the Commissioner

According to this section, the Commissioner shall have the powers, authorities, and duties vested in him by virtue thereof and also, the power, authorities, and duties established in title 22 of the Insurance Code of the Virgin Islands.

§ 1906. Restriction Relating to Premium Rates

- (a) The premium rate charged by a health insurance organization or insurer offering a health insurance plan providing health insurance coverage may vary only, with respect to the particular coverage involved, on the basis of the following:
 - (1) Whether the coverage covers an individual or family:
 - (A) For family coverage, the total premium for family coverage must be determined by summing the premiums for each individual family member; and
 - (B) For family coverage, any rating variation on the basis of age or tobacco use and health factor must be applied separately to the portion of the premium attributable to each covered family member;
 - (2) Age:

- (a) The rate may not vary based on age by more than 3:1 for like individuals of different age who are twenty-one (21) and older, and the variation in rate must be actuarially justified for individuals under age twenty-one (21);
 - (b) The rate of each enrollee must be based on the enrollee's age as of the date of policy issuance, renewal or addition to the policy;
 - (c) Variations in rates based on age must be consistent with the uniform age rating curve established by HHS under 45 CFR §147,102(e), unless the Commissioner establishes an alternative age rating curve pursuant to subparagraph (d) of this paragraph; and
 - (d) The Commissioner may adopt regulations establishing a uniform age rating curve, subject to the restrictions imposed by 45 CFR §147,102(e). Any uniform age rating curve must be based on the following uniform age bands:
 - (i) A single band for individuals age 0 through 20.
 - (ii) One-year age bands for individuals age 21 through 63; and
 - (iii) A single age band for individuals age 64 and older.
- (3) Tobacco use:
- (a) The rate may not vary by more than 1.5:1 on the basis of tobacco use;
 - (b) A rating surcharge for tobacco use may only be applied to individuals who may legally use tobacco under federal and state law;
 - (c) A rating surcharge for "tobacco use" may only be applied to individuals who have used tobacco on average four (4) or more times per week within the most recent six-month period; and
 - (d) The health insurer may consider the use of any tobacco product for rating purposes, but may not consider religious or ceremonial use of tobacco. Further, the health insurer must consider "tobacco use" in terms of when a tobacco product was last used.
- (4) Health factors:
- The rate may not vary by more than 3:1 on the basis of health factors and must be actuarially justified.
- (b) A premium rate may not vary with respect to a particular coverage by any other factor not described in Subsection(a)

§ 1907. Guaranteed Availability of Group and Individual Market Health Insurance Coverage; Enrollment Periods.

- (a) Subject to subsections (b) through (d), a health insurance organization or insurer offering a health insurance plan providing group or individual market health insurance coverage must offer to any group employer or individual in the territory all products that are approved for sale on the group or individual market and must accept any individual or employee that applies for coverage under any of those products.
- (b) A health insurance organization or insurer may restrict enrollment in health insurance coverage to open or special enrollment periods.

- (c) (1) A health insurance organization or insurer must allow a group employer or individual to purchase health insurance coverage during a broader open enrollment period. Coverage must become effective consistent with the dates described in paragraph (2).
- (2) The health insurance organization or insurer must ensure coverage is effective for group employers or individuals who have applied for coverage under the health insurance plan in accordance with requirements established by the Commissioner.
- (d) For group employers or individuals enrolled in non-calendar year health plans, a health insurance organization or insurer must provide a limited open enrollment period that begins on the date that is thirty (30) calendar days prior to the date the policy year ends in 2016. The effective date of coverage under this subsection must be consistent with the date described in Subsection (e)(2)(B).
- (e)(1) (A) In addition to the special enrollment periods provided in this Act and qualifying events, as defined under Section 603 of Employee Retirement Income Security Act of 1974 (ERISA), a health insurer must provide special enrollment periods for the following triggering events:
 - (i) An individual or dependent loses coverage;
 - (ii) An individual gains a dependent through marriage, birth, adoption or placement for adoption or placement on foster care;
 - (iii) An individual or covered person gains access to new health plans as a result of a permanent move.
- (B) These special enrollment periods are in addition to any other special enrollment periods required under Virgin Islands or Federal law.
- (2) (A) With respect to an election made under subsection (d) or paragraph (1) of this subsection, coverage must become effective consistent with the dates described in subparagraph (B) of this paragraph.
- (B) Except as provided in subparagraph (iii) of this paragraph, for a health insurance plan selection received by the health insurer from an individual:
 - (i) Between the first and the fifteenth day of any month, the health insurer must ensure a coverage effective date of the first day of the following month; and
 - (ii) Between the sixteenth and the last day of any month, the health insurer must ensure a coverage effective date of the first day of the second following month.
- (C)(i) In the case of birth, adoption or placement for adoption, the health insurer must ensure that coverage is effective regardless of the enrollment date in accordance with the provisions of subsection e(1)(A)(ii) on the date of birth, adoption or placement for adoption.
- (ii) In the case of marriage, or in the case where an individual loses coverage, as described in subsection (e)(1)(A)(i), the health insurer must ensure coverage is effective on the first day of the following month.

§ 1908. Guaranteed Renewability of Group and Individual Market Health Insurance Coverage

- (a) As provided in subsection (b), a health insurance organization or insurer offering a health plan providing group or individual market health insurance coverage subject to this Act must renew or continue in force the coverage at the option of the employer or individual.
- (b) A health insurance organization or insurer may nonrenew or discontinue health insurance coverage based only on one or more of the following:
 - (1) The group employer or individual has failed to pay premiums, considering the grace period, in accordance with the terms of the health insurance coverage;
 - (2) The group employer or individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage;
 - (3) The insurer is ceasing to offer a particular product in the market or discontinuing all coverage. In these cases, the insurer shall provide a written notice to the Commissioner, the employer and the covered persons or enrollees, of its decision not to renew coverage at least one hundred and eighty (180) days prior to the nonrenewal of the health plans.
 - (4) For network plans, there is no longer any covered person who lives, resides or works in the service area of the insurer (or the area for which the insurer is authorized to do business).
 - (5) For coverage made available in the individual market only through one or more bona fide associations, the individual's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered persons.
 - (6) When the Commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders or would impair the insurer's ability to meet its contractual obligations.
- (c)
 - (1) At the time of coverage renewal only, a health insurer may modify the health insurance coverage for a product offered in the group or individual market if the modification is consistent with Virgin Islands law and is effective uniformly among all policyholders with that product.
 - (2) For purposes of paragraph (1), a modification made uniformly and solely pursuant to applicable state requirements is considered a uniform modification of coverage if:
 - (i) The modification is made within a reasonable time period after the imposition or modification of Virgin Islands requirement; and
 - (ii) The modification is directly related to the imposition or modification of the Virgin Islands requirement.
 - (3) Other types of modifications made uniformly are considered a uniform modification of coverage if the group or individual market health insurance coverage for the product meets all of the following criteria:

- (i) The product is offered by the same health insurer, as that term is defined in the Act;
 - (ii) The product is offered as the same product network type;
 - (iii) The product continues to cover at least a majority of the same service area;
 - (iv) Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost-sharing solely related to changes in cost and utilization of health care services; and
 - (v) The product provides the same covered benefits, except any changes in benefits that cumulatively impact the plan-adjusted index rate, for any plan within the product within an allowable variation of +/- two (2) percentage points, not including changes pursuant to applicable Virgin Islands requirements.
- (d) If a health insurer is renewing non-grandfathered group or individual market health insurance coverage as described in Subsection a, or uniformly modifying non-grandfathered group or individual market health insurance coverage as described in subsection c, the health insurer must provide to each individual or employer written notice of the renewal before the date of the first day of the next open enrollment period in a form and manner specified by the Commissioner.
- (e) (1) Nothing in this section should be construed to require a health insurer to renew or continue in force group or individual market health insurance coverage for which continued eligibility would otherwise be prohibited under applicable federal or Virgin Islands law.
- (2) Medicare eligibility or entitlement to such benefits is not a basis for non-renewal or termination of an individual's health insurance coverage in the individual market.
- (f) This section applies to grandfathered health plan coverage in accordance with 45 CFR §147.140 to the extent the grandfathered health plan coverage was required to comply with the guaranteed renewability provisions under Section 2742 of the PHSA in effect pursuant to Pub. L. No. 104-191 (HIPAA) prior to the effective date of this Act.

§ 1909. Preexisting Condition Exclusions

- (a) A health insurance organization or insurer offering a health plan providing individual market health insurance coverage may impose preexisting condition exclusions except as it relates to the treatment and diagnosis of diabetes, blood pressure and coronary heart disease or required by Virgin Islands law.
- (b) Group health plans are still prohibited from applying preexisting condition exclusions to group plans under the Employee Retirement Income Security Act (ERISA).

§ 1910. Limitation Based on Health Factors

(a) (1) A health insurance organization or insurer offering a health insurance plan providing group or individual market health insurance coverage subject to this Act may establish a rule for eligibility, including continued eligibility, of an employer or individual to enroll in benefits under the plan consistent with this Act or Federal law, if applicable.

- (2) For purposes of this section, a rule of eligibility includes a rule relating to:
- (A) Enrollment;
 - (B) The effective date of coverage;
 - (C) Waiting or affiliation periods;
 - (D) Late and special enrollment;
 - (E) Eligibility for benefit packages, including rules for individuals to change their selection among benefit packages;
 - (F) Benefits, including a rule relating to covered benefits, benefit restrictions, and cost-sharing mechanisms, such as coinsurance, copayments and deductibles, as described in subsection C(1) and (2);
 - (G) Continued eligibility; and
 - (H) Terminating coverage, including disenrollment, of an individual under the plan.

(3) Nothing in this section prohibits a health insurance organization or insurer from establishing more favorable rules of eligibility for individuals with an adverse health factor, such as a disability, than for individuals without the adverse health factor.

(b) (1) Subject to federal or Virgin Islands law or regulations and paragraph (2), subsection (a) does not require a health insurance organization or insurer offering a health insurance plan providing individual market health insurance coverage subject to the Act to provide coverage for any particular benefit to similarly situated individuals.

- (2) (A) A health insurance organization or insurer offering a health insurance plan providing individual market health insurance coverage subject to the Act shall make the benefits provided under a plan available uniformly to all individuals.
- (B) For any restriction on a benefit or benefits provided under a plan, the health insurance organization or insurer:
- (i) Shall apply the restriction uniformly; and
 - (ii) May not direct the restriction, as determined based on all of the relevant facts and circumstances, at any individual or dependents of an individual based on any health factor of the individual or a dependent of the individual.
- (C) The health insurance organization or insurer may require a deductible, copayment, coinsurance or other cost-sharing requirement in order to obtain a benefit under the plan if the cost-sharing requirement:
- (i) Applies uniformly;

- (ii) Is not directed at any individual or dependents of an individual based on any health factor of the individual or dependent of an individual; and
 - (iii) Does not apply to preventive benefits specified in Section 2713 of the Public Health Service Act (PHSA).
- (D) For purposes of this paragraph, a plan amendment applicable to all individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual or dependent of an individual.
- (3) If the health insurance organization or insurer generally provides benefits for a type of injury, the health insurer may not deny any individual or dependent of an individual benefits otherwise provided under the plan for treatment of the injury if the injury results from an act of domestic violence or a medical condition. This provision applies to an injury resulting from a medical condition even if the medical condition is not diagnosed before the injury.
- (c) In accordance with subsection (a), a health insurance organization or insurer offering a health insurance plan providing individual market health insurance coverage subject to the Act may not establish a rule of eligibility or set an individual policyholder's premium or contribution rate based on:
 - (1) Whether the policyholder is confined in a hospital or other healthcare institution; or
 - (2) The policyholder's ability to engage in normal life activities.

§ 1911. Prohibition on waiting Periods that exceed 90 days

- (a) **General rule.** A group health insurance plan, and a health insurance organization or insurer offering individual health insurance coverage, must not apply any waiting period that exceeds 90 days, in accordance with this section. If, under the terms of a plan, an individual can elect coverage that would begin on a date that is later than the end of the 90-day waiting period, this paragraph (a) is considered satisfied. Accordingly, in that case, a plan or insurer will not be considered to have violated this paragraph (a) solely because individual's take, or are permitted to take, additional time (beyond the end of the 90-day waiting period) to elect coverage.
- (b) **Waiting period defined.** For purposes of the section, a waiting period is the period that must pass before coverage for an individual or employer who is otherwise eligible to enroll under the terms of a group health insurance plan can become effective. If an individual enrolls as a late enrollee (as defined in 26 CFR 54.9801-3(a)(3)(v) and (vi) or special enrollee (as described in 29 CFR 2590.701-6), any period before such late or special enrollment is not a waiting period.

§ 1912. Eligibility of children until age 26.

A group health insurance plan, or a health insurance organization or insurer offering group or individual health insurance coverage, that makes available dependent coverage of children shall continue to make such coverage available for an adult child (who are not married) until attainment of 26 years of age.

§ 1913. Lifetime or annual limits.

(1) *Lifetime limits.* A health insurance organization or insurer offering individual health insurance coverage, may establish Reasonable lifetime limit on the dollar amount of benefits for any individual.

(2) *Annual limits.* A health insurance organization or insurer offering individual health insurance coverage, may establish Reasonable annual limit on the dollar amount of benefits for any individual.

§ 1914. Prohibition on Rescissions

A group health insurance plan, or a health insurance organization or insurer offering individual health insurance coverage, must not rescind coverage under the plan, or under the policy, certificate, or contract of insurance, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. A group health plan, or a health insurance insurer offering individual health insurance coverage, must provide at least 30 days advance written notice to each participant (in the individual market, primary subscriber) who would be affected before coverage may be rescinded under this paragraph (a)(1), regardless of, in the case of group coverage, whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. The rules of this paragraph apply regardless of any contestability period that may otherwise apply.

§ 1915. Coverage of Preventative Health Services

(a) *Services*

(1) *In general.* A group health plan, or a health insurance organization or insurer offering individual health insurance coverage, may provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible) with respect to those items and services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for

Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children, and adolescents up to twenty-one (21) years of age, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, preventative care and screening services as provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

(2) Office visits

(i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or insurer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or insurer may not impose cost-sharing requirements with respect to the office visit.

(iii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or insurer may impose cost-sharing requirements with respect to the office visit.

§ 1916. Essential Health Benefits Package

- (a) To meet the requirements of this section, the provision of essential health benefits means that a health benefit plan provides health benefits that:
- (1) Are substantially equal to the EHB-benchmark plan including:
 - (A) Covered benefits;
 - (B) Limitations on coverage including coverage of benefit amount, duration and scope; and
 - (C) Prescription drug benefits that meet the requirements of this Act;
 - (2) With the exception of the essential health benefits category of coverage for pediatric services, do not exclude an enrollee from coverage in an essential health benefits category;
 - (3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, comply with the requirements of 45 CFR §146.136 related to parity in mental health and substance use disorder benefits;
 - (4) Include preventive health services, as provided in Section 1904(b);
 - (5) If the EHB-benchmark plan does not include coverage for habilitative services, include habilitative services in a manner that meets one of the following:

- (a) Provides parity by covering habilitative services benefits that are similar in scope, amount and duration to benefits covered for rehabilitative services;
 - (b) Is determined by the health insurer and reported to HHS; or
 - (c) As determined by the Territory as provided in 45 CFR §156.110(f).
- (b) A health insurance organization or insurer offering a health insurance plan in the group or individual market providing essential health benefits may substitute benefits if the insurer meets the following conditions:
 - (1) Substitutes a benefit that:
 - (a) Is actuarially equivalent to the benefit that is being replaced as determined in paragraph (2);
 - (b) Is made only within the same essential health benefit category; and
 - (c) Is not a prescription drug benefit; and
 - (2) Submits evidence of actuarial equivalence that is:
 - (a) Certified by a member of the American Academy of Actuaries;
 - (b) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;
 - (c) Based on a standardized plan population; and
 - (d) Determined regardless of cost-sharing.
- (c) A health insurance plan does not fail to provide essential health benefits solely because it does not offer the services described in 45 CFR §156.280(d).
- (d) A health insurance organization or insurer offering a health insurance plan in the individual market providing essential health benefits may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits or non-medically necessary orthodontia as essential health benefits.
- (e) A health insurance organization or insurer offering health insurance plan in the group or individual market providing essential health benefits may not impose annual and lifetime dollar limits on essential health benefits in accordance with 45 CFR §147.126.

§ 1917. Parity in Mental Health and Substance Use Disorder Benefits

- (a)
 - (1) The provisions of 45 CFR §146.136 apply to a health insurance organization or insurer offering a health insurance plan to small group or individual market in the same manner and to the same extent as such provisions apply to health insurance coverage offered in connection with a group health insurance plan in the large group market.
 - (2) For purposes of this subsection, “large group market” has the meaning stated in 45 CFR §144.103.
- (b) This section applies to all health plan coverage.

§ 1918. Sanctions

Any violations of the provisions of this Act or the rules or regulations promulgated thereunder for which a sanction or penalty has not been expressly prescribed shall be subject to an administrative fine of not less than five hundred dollars (\$500) or more than ten thousand dollars (\$10,000) for each violation.

Chapter II. IV Small Group Employer Health Insurance Availability

Section 1919. Title

This subchapter shall be known and may be cited as the Subchapter on Small Group Employer Health Insurance Availability.

Section 1920. Purpose

The purpose of this subchapter is to enhance the availability of health insurance coverage to small group employers, regardless of the health status or claims experience of their employee group, to prevent abusive rating practices, to prevent segmentation of the health insurance market based upon health risk; to establish rules regarding renewability of health plans; to limit the use of preexisting condition exclusions; to provide for development of group health plans to be offered to all small group employers; and to improve the overall fairness and efficiency of the small group health insurance market.

Section 1921. Definitions

For purposes of this Subchapter

- (a) “Affiliate” or “Affiliate Company” means any entity or person that directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under the same control of that specific entity or person.
- (b) “Geographic Service Area” means a geographic area, as approved by the Commissioner, within which the insurer is authorized to provide coverage under the provisions of this Subchapter.
- (c) “Small Group Employer Insurer” or “Insurer” means any entity authorized by the Commissioner to offer health plans to eligible employees of one or more small group employers pursuant to this subchapter. For purposes of this subchapter “insurer” includes an insurance company, a prepaid hospital or medical care plan, a fraternal benefit society, a health services organization, and any other entity offering and providing a health plan or health benefits subject to insurance regulation in the Virgin Islands.
- (d) “Actuarial Certification” shall mean a signed statement from a member of the American Academy of Actuaries or other individual acceptable to the Commissioner that a small group employer insurer is in compliance with the provisions of this Subchapter. Such certification shall be based upon the person’s examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the insurer in establishing premium rates for applicable insurance coverage.
- (e) “Creditable Coverage” means, with respect to an individual, the health benefits or coverage provided under any of the following:

- (1) A health plan, whether group or individual;
 - (2) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
 - (3) Title XIX of the Social Security Act (Medicare), other than coverage consisting solely of benefits under Section 1928 (the program for distribution of pediatric vaccines);
 - (4) Chapter 55 of Title 10, United States Code; (medical and dental care for members and certain former members of the uniformed services, and for their dependents. For purposes of Title 10, U.S.C. Chapter 55, “uniformed services” means the armed forces and the Commissioned Corps of the national Oceanic and Atmospheric Administration and of the Public Health Service);
 - (5) A state health benefits risk pool;
 - (6) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP));
 - (7) A public health plan, which for purposes of this subchapter, means a plan established or maintained by a state, the United States government or a foreign country or any political subdivision of a state, the United States government or a foreign country that provides health insurance coverage to individuals enrolled in the plan;
 - (8) A health plan under Section 5(e) of the Peace Corps Act (22U.S.C.2504(e)); or
 - (9) Title XXI of the Social Security Act (State Children’s Health Insurance Program).
A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under a group plan, if, after such period and before the enrollment date, the individual experiences a significant break in coverage. Significant break in coverage shall be understood as a period of sixty-three (63) consecutive days during which the individual does not have any creditable coverage. A waiting period or an affiliation period shall be taken into account in determining the sixty-three (63) – day period.
- (f) “Eligible Employee” means an employee who works for a Small group employer on a fulltime basis – a normal work week of 30 or more hours – or on a part-time basis – a normal work week of 30 or more hours – or on a part-time basis – a normal work week of at least seventeen point five (17.5) hours – in a bona fide employer-employee relationship which has not been established for the purpose of acquiring a health plan. In this computation, those employees who are not currently working as a result of any leave or right recognized by law, such as the benefits provided by the Family and Medical Leave Act of 1993, shall be included. The term “eligible employee” shall not include temporary employees or independent contractors.
- (g) “Preexisting Condition Exclusion” means a limitation or exclusion of benefits relating to a condition based on the fact that the condition, injury, or disease was present before the enrollment date of the health plan. Genetic information shall not be treated as a condition exclusion may be imposed in the absence of a diagnosis of the condition related to the information.
- (h) “Enrollment Date” means the first day of coverage, or if there is a waiting period, the first day of the waiting period, whichever comes first.

- (i) “Genetic Information” means information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This includes information regarding insurer status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.
- (j) “Small group employer” means a for profit or non-profit person, corporation, partnership, association that on at least fifty percent (50%) of its working days during the preceding calendar year, employed at least two (2), but not more than fifty (50) eligible employees.
- (k) “Waiting Period” means the period of time that must pass before coverage for a covered person or enrollee who is otherwise eligible to enroll under the terms of a health plan can become effective. In no case the waiting period shall exceed ninety (90) days.
- (l) “Enrollment Period” means a period of time established for an eligible employee to enroll in Small group employer – sponsored health plan.
- (m) “Covered Person” or “Enrollee” means the holder of a policy or certificate, or other individual participating in a Small group employer – sponsored health plan
- (n) “Preferred Network Plan” means a health plan under which benefits shall be provided, in whole or in part, through providers under contract with the insurer.
- (o) “Basic Health Plan” means a health plan that provides only minimal coverage. For example, it may cover preventative visits to a physician and catastrophic events. It usually has high deductibles and low premiums.
- (p) “Catastrophic Health Plan” provides coverage for essential health benefits after the member pays for cost sharing equal to maximum out-of-pocket limits.
- (q) “Standard Health Plan” means a health plan that provides increased coverage, the cost of which is higher than that of a basic health plan.
- (r) “Group Health Plan” means a policy, contract, or certificate offered by a health insurance organization or insurer to small group employer whereby healthcare services are provided to eligible employees and their dependents.
- (s) “Premium” means all moneys paid to an insurer as a condition of receiving the benefits of a health plan for the eligible employees of small group employers
- (t) “Producer” means a person who, in accordance with the Insurance Code of the Virgin Islands, holds a license duly issued by the Commissioner to transact insurance business in the Virgin Islands.
- (u) “Late Enrollee” means an eligible employee or dependent that enrolls in a small group employer – sponsored health plan after the initial enrollment period, provided that such term shall never be less than thirty (30) days.

No eligible employees or dependent shall be considered a late enrollee:

- (1) If the eligible employee or dependent meets each one of the following criteria:
 - (a) was covered under a creditable coverage at the time of initial enrollment;
 - (b) lost creditable coverage as a result of cessation of employer contribution, termination of employment or loss of eligibility, reduction

in the number of work hours, involuntary termination of a creditable coverage, death of a spouse, legal separation or divorce; and

(c) requests enrollment within thirty (30) days after termination of creditable coverage or the change in conditions that gave rise to the termination of coverage.

- (2) If, where provided for in the health plan, or as otherwise provided by law, the eligible employee or dependent enrolls during specified enrollment period;
- (3) If the eligible employee is employed by an employer that offers multiple health plans, and he/she elects a different health plan during the enrollment period.
- (4) If a court has ordered coverage be provided for a spouse or minor or dependent child under an employee's health plan and a request for enrollment is made within thirty (30) days after the change in status;
- (5) If the individual changes status from not being an eligible employee to becoming an eligible employee and requests enrollment within thirty (30) days after the change in status.
- (6) If the eligible employee or dependent had coverage under a Consolidated Omnibus Budget Reconciliation (COBRA) continuation provision and the coverage under that provision has been exhausted; or
- (7) The eligible employee meets the requirements for special enrollment pursuant to this Subchapter.

Section 1922. Applicability and Scope

- (a) This subchapter shall apply to a health insurance organization or insurer that offers health plans to the employees of the small group employers in the Virgin Islands provided that the small group employer pays all or part of the premium or benefits, or the eligible employee is reimbursed for any portion of the premium, whether through wage adjustments or otherwise, as agreed upon by the parties.
- (b) For the purpose of this subchapter, health insurance organizations or insurers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one insurer and any restrictions or limitations imposed by this subchapter shall apply as if all health plans issued for delivery to small group employers in the Virgin Islands by such affiliated insurers were issued by one insurer.

Section 1923. Premium Rates.

- (a) The premium charged for a health plan may not be adjusted more frequently than annually, except that the rates may be changed to reflect;
 - (1) Changes to the enrollment of the small group employer;
 - (2) Changes to the family composition of the eligible employee; or
 - (3) Changes to the health plan requested by the small group employer.
- (b) Each health insurance organization or insurer shall maintain at its principal place of business, for review by the Commissioner, a complete and detailed description of its rating practices and renewal underwriting practices. In addition, such health insurance

organization or insurer shall maintain information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles. Also, health insurance organizations or insurers shall meet the following requirements:

- (1) Each small group employer insurer shall file with the Commissioner annually, not later than March 15, an actuarial certification certifying that it is in compliance with this subchapter and that the rating methods of the small group employer insurer are actuarially sound. The certification shall be in the form or manner, and shall be retained by the small group employer insurer at its principal place of business.
- (2) A small group employer insurer shall make the information and documentation described in subsection (e) available to the Commissioner upon request. Except in cases of violations of the subchapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the Commissioner to persons outside of the Division of Banking and Insurance except as agreed to by the health insurance organization or insurer or as ordered by a court of competent jurisdiction.
- (c) As provided in 22 V.I.C. 53a, the Commissioner shall be notified 30 days in advance of the effective date of any rate increase. The Commissioner may review any health insurance rate to determine if there is an actuarial basis for it and if it is supported by actual and credible loss and expense statistics or, if new coverage, by reasonable projections of losses and expenses.
- (d) The requirements of this section shall apply to all group health plans issued or renewed on or after the effective date of this Act.

Section 1924. Renewability of Health Plan

- (a) A health insurance organization or insurer providing health plans to small group employer shall renew the same to all eligible employees and their dependents, except in any of the following cases:
 - (1) Failure to pay premiums, considering the grace period;
 - (2) When the covered person or enrollee has performed an act that constitutes fraud. In such case the insurer may choose not to renew the health plan of such covered person or enrollee for one (1) year as of the coverage's termination date;
 - (3) When the covered person or enrollee has or made an intentional misrepresentation of material fact under the terms of coverage. In such case the insurer may choose not to renew the health plan of such covered person or enrollee for one (1) year as of the coverage termination date;
 - (4) Noncompliance with the insurer's minimum participation requirements, pursuant to the provisions of this subchapter;
 - (5) Noncompliance with the insurer's employer contribution requirements;
 - (6) When the health insurance organization or insurer elects to discontinue offering all of its health plans of small group employers in the Virgin Islands. In these cases, the insurer shall provide a written notice to the Commissioner, the small group employer,

and the covered persons or enrollees, of its decision not to renew coverage at least one hundred and eighty (180) days prior to the nonrenewal of the health plans.

(7) When the Commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders or would impair the insurer's ability to meet its contractual obligations;

(8) In the case of health plans that are made available in the small group market through a preferred network plan, there is no longer an employee of the Small group employer living, working, or residing within the insurer's established geographic service area.

(b) In addition to comply with the provisions of this Section, the insurer shall comply, at all times, with the applicable Federal regulations, as codified under 45 C.F.R. Section 146.153(Guaranteed renewability of coverage for employers in the group market).

Section 1925. Availability of Health Plan

(a) Every health insurance organization or insurer offering insurance to small group employers shall, as a condition of transacting business in the Virgin Islands with small group employers and as otherwise provided in this subchapter, actively offer all health plans it actively markets to small group employers. Insurers shall also meet the following availability requirements:

(1) A small group employer insurer shall issue a health plan to any eligible employer that applies for such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health plan not inconsistent with this subchapter.

(2) Unless otherwise provided by the Commissioner, the small group employer insurer shall not enter into one or more ceding agreements with respect to health plans delivered or issued for delivery for small group employers in the Virgin Islands, if such arrangements would result in more than fifty (50) percent of the insurance obligation or risk for such health plan being retained by the ceding insurer.

(b) Small group employer shall file with the Commissioner the health plan form and rates they intend to use in the market. The small group employer insurer may begin using such forms and rates thirty (30) days after they are filed unless the Commissioner disapproves its use. Provided that:

(1) The Commissioner, at any time, may extend such term for not more than sixty (60) additional days.

(2) The Commissioner at any time may, after providing notice and an opportunity for a hearing, disapprove the use of such health plan on grounds that the plan does not meet the requirements of this subchapter, Federal law or the regulations thereunder.

(c) Health plans covering small group employers shall comply with the following provisions:

(1) A health plan shall not deny, exclude or limit benefits due to a preexisting condition,

(2) Furthermore, small group employer insurer shall comply with the following provisions regarding preexisting conditions:

- (A) A Small group employer insurer shall reduce the period of any preexisting condition denial, limitation, or exclusion provided that the person has had creditable coverage ended on a date not more than ninety (90) days prior to the enrollment date of new health plan. The reduction provided in this paragraph shall be for the entirety of the creditable coverage period.
 - (B) A health insurance organization or insurer that does not use preexisting condition limitations in any of its health plans may impose an affiliation period that shall not exceed sixty (60) days for new enrollees and ninety (90) days for late enrollees. Such affiliation periods shall apply uniformly without regard to any health status-related factor.
- (3) Small group employer insurers shall not impose exclusion for preexisting condition.
- (4) Health insurance organizations or insurers shall permit late enrollees to enroll for coverage under the terms of the health plan during a special enrollment period if:
- (A) The late subscriber was covered under a health plan at the time small group employer sponsored health plan was previously offered, including a health plan under the Consolidated Omnibus Budget Reconciliation Plan Act (COBRA).
 - (B) The other health plan of the later subscriber has been terminated as a result of loss of eligibility for coverage, including a legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions towards that other coverage have been terminated; and
 - (C) the late subscriber requests enrollment in a small group employer sponsored health plan not later than thirty (30) days after the date termination of coverage under another plan.
- If an employee enrollment pursuant to paragraph (7), the small group employer-sponsored health plan shall be effective not later than the first calendar month after the date on which the request for enrollment was received.
- (5) Insurers that provide Small group employer health plans shall establish a dependent special enrollment period during which the dependent and the eligible employee, if not otherwise enrolled, may be enrolled under the health plan and, in the case of the birth or adoption of a child, award of custody, or guardianship, or marriage. The special enrollment period for persons who comply with the provisions of this paragraph (8) shall be a period of thirty (30) days and shall begin on the latter date of:
- (A) The date on which the health plan is made available for such dependent; or
 - (B) The date of the marriage, birth or adoption, or award of custody or guardianship.
- If an eligible employee seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period, the effective date of the health plan of the dependent shall be:
- (i) In the case of a dependent's birth, as of the month beginning after the date on which the request for enrollment was received;
 - (ii) In the case of a dependent's adoption award of custody or guardianship, the date of the adoption or award.
- (6) Small group employer insurers shall not require a minimum participation level greater than:

- (A) One hundred percent (100%) of eligible employees working for employers of three (3) or less employees; and
- (B) Seventy-five percent (75%) of eligible employees working for employers with more than four (4) employees.

In applying minimum participation requirements with respect to a Small group employer, an insurer shall not consider employees or dependents who have creditable coverage in determining whether the applicable percentage of participation is met. Individuals covered under a health plan pursuant to continuation provisions of COBRA shall be considered.

Insurers shall not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to the Small group employer at any time after such employer has been accepted for the health plan.

(7) (A) An insurer that offers a health plan shall offer the same plan to all eligible employees of such small group employer and their dependents. Insurers shall not offer coverage to only certain individuals or dependents in the group.

(B) Small group employer insurers shall not place any restriction in regard to any health status-related factor on an eligible employee or dependent with respect to enrollment or plan participation.

(C) Except as permitted under this subchapter, insurers shall not modify a health plan with respect to a small group employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits of the health plan related to specific diseases, medical conditions, or services.

(d) Small group employer insurer shall not be required to offer health plans or accept applications in the case of the following:

(1) To a small group employer, if such employer is not located in the insurer's established geographic service area;

(2) To an employee, if the employee does not live, work or reside within the insurer's established geographic service area.

Insurers shall apply the provisions of this section uniformly to all small group employers, regardless of their claim experience or any health status-related factor of their eligible employees and their dependents.

(e) Small group employer insurers shall not be required to offer health plans to small group employers if, for any period of time, the Commissioner determines the insurer does not have the financial reserves necessary to underwrite health plans. In these cases, the insurer may not offer health plan in the small group employer market for the later of:

(1) A period of one hundred and eighty (180) days after the date the Commissioner made the decision; or

(2) Until the insurer has demonstrated to the Commissioner that it has sufficient financial reserves to underwrite additional health plans to Small group employer and the Commissioner has authorized it again to offer health plans Small group employer.

(f) A small group employer insurer shall not be required to provide coverage to small group employers if the insurer elects, not to offer new health plan to small group employers in the Virgin Islands. Provided, further, that:

(1) the insurer that elects not to offer new health plans to small group employers may be allowed to maintain its existing policies in the Virgin Islands, as determined by the Commissioner.

(2) the insurer that elects not to offer new health plans to small group employers shall provide notice of its election to the Commissioner.

Section 1926. Certification of Creditable Coverage

- (a) Small group employer insurers shall provide written certification of creditable coverage to individuals in accordance with subsection (b).
- (b) The certification of creditable coverage shall be provided:
 - (1) At the time an individual ceases to be covered under the health plan or otherwise becomes covered under a Cobra continuation provision;
 - (2) In the case of an individual who becomes covered under a COBRA continuation provision at the time the individual ceases to be covered under that provision.
- (c) The certificate of creditable coverage required to be provided pursuant to this section shall contain:
 - (1) The period of creditable coverage of the individual under the other health plan; and
 - (2) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under another health plan.

Section 1927. Standards to Assure Fair Marketing

- (a) Each health insurance organization or insurer shall actively market all health plans sold by the health insurance organization or insurer to all small group employers in the Virgin Islands.
- (b) No small group insurer or producer shall, directly or indirectly, engage in the following activities:
 - Encouraging or directing small group employers to refrain from filing an application for coverage with the small group employer insurer because of any health status-related factor, industry, occupation or geographic location of the small group employer..
- (c) No health insurance organization or insurer shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer that provides for or results in the compensation paid to a producer for the sale of a health plan to be varied because of any initial or renewal health status-related factor of eligible employees or dependents, or industry, occupation or geographic location of the small group employer. This provision shall not apply with respect to compensation to a producer on the basis of percentage of premium, provided that the percentage shall not vary because of any health status-related factor of eligible employees or dependents, or industry, occupation or geographical location of the small group employer.
- (d) No health insurance organization or insurer may terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to any initial or renewal health status-related factor of eligible employees or dependents, or industry, occupation or geographic location of the small group employer placed by the producer.

- (e) A health insurance organization or insurer or producer may not induce or otherwise encourage a small group employer to separate or otherwise exclude an eligible employee or dependent from the benefits of a health plan.
- (f) Denial by a health insurance organization or insurer of an application for health plan from a small group employer, for any of the reasons permitted in accordance with the provisions of this subchapter, shall be in writing and shall state the reason or reasons for the denial.
- (g) Any violation of this subsection shall be an unfair trade practice under chapter 49 of the Insurance Code of the Virgin Islands and shall be subject to the sanctions provided therein. If an insurer enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health plans to small group employer in the Virgin Islands, the third-party administrator shall be subject to this subsection as if it were an insurer.

Section 1928. Required Disclosure

- (a) In connection with the offering for sale of any health plan to a small group employer, the health insurance organization or insurer shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:
 - (1) The provisions of the health plan that, in accordance with this subchapter, grant the insurer the right to change rates and the factors therefor, other than claim experience.
 - (2) The provisions related to the possibility of renewal of policies and contracts.
 - (3) The provisions related to preexisting conditions.
 - (4) A listing and descriptive information, including benefits and premiums, on all health plans available for small group employers

II.II Prescription Drug Management

Section 1929. Title

This subchapter shall be known and may be cited as the subchapter on Prescription Drug Management.

Section 1930. Purpose

The purpose of this subchapter is to provide standards for the development, maintenance, and management of prescription drug formularies and other procedures as part of the prescription drug benefits established by health insurance organizations or insurers that provide such services.

Section 1931. Definitions

For purposes of this chapter:

- (a) “Prior Authorization” means the process of obtaining prior approval from a health insurance organization or insurer, required under the terms of a health plan, for coverage of a prescription drug.

- (b) “Pharmacy and Therapeutics Committees” means a committee or equivalent body that is comprised of individuals who are either employed by or under contract with the health insurance organization or insurer, which shall be composed of an odd number of members. The members of the Pharmacy and Therapeutics Committee shall be healthcare professionals, such as physician and pharmacists, who have knowledge and expertise in:
- (1) Clinically appropriate prescribing, dispensing, and monitoring of outpatient prescription drugs; and
 - (2) Drug use review, evaluation, and intervention.
- If there were any representatives of the pharmacy benefits manager, the health insurance organization, or insurer among the members of the Pharmacy and Therapeutics Committee, the same shall only contribute with operations and logistic considerations, but shall not vote on issues related to adding or excluding prescription drug from the formulary.
- (c) “Clinical Review Criteria” mean the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a healthcare organization or insurer to determine medical necessity and appropriateness of healthcare services.
- (d) “Medical or Scientific Evidence” means evidence found in any of the following sources:
- (1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts;
 - (2) Peer-reviewed medical literature, including literature related to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meets the criteria of the National Institutes of Health’s Library of medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medica (EMBASE);
 - (3) Medical journals recognized by the Secretary of Health and Human Services of the United States Government under the Federal Social Security Act;
 - (4) The following standard reference compendia:
 - (A) the American Hospital Formulary Service- Drug Information;
 - (B) Drug Facts and Comparisons;
 - (C) The American Dental Association Accepted Dental Therapeutic;
 - and
 - (D) The United States Pharmacopeia-Drug Information;
 - (5) Findings, studies, or research conducted by or under the auspices of Federal government agencies and Federal research institutes recognized in the United States of America, including:
 - (A) the Agency for Healthcare Research and Quality;
 - (B) the National Institutes of Health;
 - (C) the National Cancer Institute;
 - (D) the National Academy of Sciences;
 - (E) the Centers for Medicare and Medicaid Services (CMS);
 - (F) the Food and Drug Administration (FDA); and

- (G) any national board recognized by the National Institutes of Health for the purposes of evaluating the medical value of healthcare services; or
- (6) Any other medical or scientific evidence that is comparable to the sources listed in clauses (1) through (5) above.
- (e) “Categorical Exclusion” mean an express determination by a health plan not to provide coverage for a prescription drug, identifying the same by its scientific or brand name.
- (f) “Formulary” means a list of prescription drugs that has been developed by a health insurance organization or insurer or its designee, which is regularly evaluated to add or exclude prescription drugs, and which the health insurance organization or insurer or its designee references in determining pharmacy coverage.
- (g) “Prescription Drug” means a drug that has been approved or regulated and that the Food and Drug Administration (FDA) has allowed to be marketed, and which the laws of the Virgin Islands and the United States require to be dispensed only through a prescription order.
- (h) “Prescription Drug Order” or “Prescription” means an order from a licensed, certified or otherwise legally authorized prescriber to a pharmacist for a prescription drug to be dispensed.
- (i) “Prescriber” means any healthcare professional legally authorized to issue prescription drug to be dispensed.
- (j) “Pharmaceutical Benefit Management Procedure” or “PHMP” includes any of the following:
- (1) A formulary;
 - (2) Dose restrictions and quantity limits;
 - (3) Prior authorization requirements; or
 - (4) Step therapy requirements.
- (k) “Grievance” means a written complaint requesting a remedy submitted by or on behalf of a covered person or enrollee, for the actions or determinations of a health insurance organization or insurer regarding:
- (1) The availability, delivery, or quality of healthcare services, including a complaint regarding an adverse determination made pursuant to utilization review;
 - (2) Claims payment, handling, or reimbursement for healthcare services; or
 - (3) Matters pertaining to the contractual relationship between a covered person or enrollee and a health insurance organization or insurer.
- (l) “Authorized Representative” means:
- (1) a person to whom the covered person or enrollee has given express written consent to represent him/her in requesting a medical exception pursuant to this subchapter
 - (2) a person authorized by law to provide substituted consent for a covered person or enrollee;

- (3) a family member of the covered person or enrollee, or the healthcare professional who is treating such covered person or enrollee, when he is unable to provide consent;
 - (4) a healthcare professional who treats or dispenses prescription drugs to the covered person or enrollee, in order to request a medical exception on the latter's behalf, pursuant to the subchapter.
- (m) "Dose Restriction" means imposing a restriction on the number of doses of a prescription drug that will be covered during a specific time period.
- (1) "Dose Restriction" does not include:
 - (A) A restriction set forth in the coverage that limits the number of doses of a prescription drug that will be covered during a specific time period; or
 - (B) A restriction on the number of doses of a prescription drug when it has been withdrawn from the market by the drug's manufacturer or it cannot be supplied.
- (n) "Generic Substitution" means the substitution of a generic version of a brand name prescription drug that has the same active ingredients, strength, and intended use as the brand name prescription drug, whose therapeutic equivalence has been recognized by the Food and Drug Administration (FDA), and is coded as such in the Approved Drug Products with Therapeutic Equivalence Evaluations, better known as the "Orange Book."
- (o) "Step Therapy" means a type of protocol that specifies the sequence in which different prescription drugs for a given medical condition are to be prescribed.

Section 1932. Applicability and Scope.

- (a) This subchapter shall apply to all health insurance organizations or insurers, or their designees, who provide or administer benefits for outpatient prescription drugs in accordance with the provisions of the health insurance plan, through the use of a formulary or through the application of any other pharmaceutical benefit management procedure.
- (b) Nothing in this subchapter shall be construed to apply to prescription drugs that are categorically or contractually excluded from a covered person or enrollee's health plan. A provision in the benefit contract that purports to exclude all nonformulary prescription drugs shall not be considered a categorical exclusion for purposes of this subchapter.

Section 1933. Requirements for the Development, Maintenance, and Management of Prescription Drug Formularies and Other Pharmaceutical Benefit Management Procedure.

- (a) Each health insurance organization or insurer that provides benefits for prescription drugs and manages such benefit through the use of a formulary or other procedure shall establish one or more Pharmacy and Therapeutics Committees, as considered appropriate by the health insurance organization or insurer, to develop, maintain, and manage such formulary and related procedures as provided in this section. The

pharmacy and Therapeutics Committee shall not participate in the benefit determination process established by the health insurance organization or insurer for the dispensation of prescription drugs.

(b) (1) The health insurance organization or insurer shall ensure that any Pharmacy and Therapeutics Committee establishes a process in writing to evaluate medical and scientific evidence concerning the safety and effectiveness of prescription drugs, including available comparative information on clinically similar prescription drugs, when deciding what prescription drugs to include on a formulary or bioequivalent and when developing other management processes. The health insurance organization or insurer shall also ensure that the Pharmacy and Therapeutics Committee uses a process for analysis and possible inclusion in the formulary of prescription drugs for off-label use, the effectiveness of which has been proven by medical and scientific evidence to treat other health conditions.

(2) Every Pharmacy and Therapeutics Committee shall maintain documentation of the process required under this paragraph and make any records and documents related to the process available, upon request, to the health insurance organization or insurer.

(c) The health insurance organization or insurer shall ensure that every Pharmacy and Therapeutics Committee adopts and follows a written process to enable it to consider the need for and implement appropriate updated and changes to the formulary in a timely manner based on:

(1) Newly available scientific and medical evidence or other information concerning prescription drugs currently listed on the formulary or subject to any other management process; and scientific and medical evidence on newly approved prescription drugs and other prescription drugs not currently listed on the formulary or subject to any other management process should be made;

(2) If applicable, information received from the health insurance organization or insurer with respect to medical exception requests to enable the Pharmacy and Therapeutics Committee to evaluate whether the prescription drugs currently listed on the formulary or subject to any other management process are meeting the healthcare service needs of covered persons or enrollees; and

(3) Information related to the safety and effectiveness of a prescription drug currently listed on the formulary or subject to any other management process, related to clinically similar or bioequivalent prescription drugs not currently listed on the formulary or subject to any other management process, information arising from the health insurance organization or insurer's quality assurance activities, or claims data that was received since the date of the Pharmacy and Therapeutics Committee's most recent review of the prescription drug.

(4) The health insurance organization or insurer shall require the Pharmacy and Therapeutics Committee to evaluate prescription drugs newly approved by the Food and Drug Administration (FDA) within a term that shall not exceed ninety (90) days counted as of the FDA's date of approval. Within a term that shall not exceed ninety (90) days, counted as of the release in the market of the new prescription drug, the Pharmacy and Therapeutics Committee shall issue its

determination as to whether or not such prescription drug shall be listed in the formulary;

- (d) Subject to this subchapter, a health insurance organization or insurer may contract with another person to perform the function of the Pharmacy and Therapeutic Committee as described in this section. Such health insurance organization or insurer shall answer to the Commissioner for the Pharmacy and Therapeutics Committee's actions, noncompliance with, and violations of this chapter.

Section 1934. Information to Prescribers, Pharmacies, Covered Persons or Enrollees, and Prospective Covered Persons or Enrollees.

- (a) Health insurance organizations or insurers shall meet the following requirements:
 - (1) Every health insurance organization or insurer shall maintain and make available to covered persons or enrollees, prescribers, and pharmacies providing healthcare services to covered persons or enrollees, by electronic means or, upon the request of a covered person or enrollee or pharmacy, in writing, the following:
 - (A) Its formulary (list of prescription drugs) by therapeutic category;
 - (B) Information indicating which prescription drugs, if any, are subject to a management procedure that has been developed and maintained pursuant to this chapter; and
 - (C) Information on how and what written documentation is required to be submitted in order for covered persons or enrollees, or their authorized representatives, to file a request under the health insurance organization or insurer's medical exceptions process established pursuant to Section 1935 of this Chapter.
 - (2) A health insurance organization or insurer shall only make changes in the formulary or other prescription drug management process during the term of the policy, certificate, or contract if such change is being made for safety reasons, because the prescription drug cannot be supplied or has been withdrawn from the market by the drug's manufacturer, or if such change entails the inclusion of prescription drugs in the formulary. To such effects, the health insurance organization or insurer shall provide or entrust a third party to provide notice of the change to:
 - (A) All covered persons or enrollees and participating pharmacies not later than the effective date of the change.

Section 1935. Medical Exceptions Approval Process Requirements and Procedures.

- (a) If the health insurance organization or insurer that provides prescription drug benefits and manages this benefit through the use of a formulary or through the application of a dose restriction that causes a prescription for a particular drug not to be covered for the number of doses prescribed, or step therapy requirements of that management process have been met, the health insurance organization or insurer shall establish and maintain

a medical exceptions process that allows covered persons or enrollee, or their authorized representatives, to request approval for:

- (1) A prescription drug that is not covered based on the formulary;
- (2) Continued coverage of a particular prescription drug whose coverage the health insurance organization or insurer shall discontinue from the formulary for reasons other than safety or because the prescription drug cannot be supplied or has been withdrawn from the market by the drug manufacturer; or
- (3) An exception to a management process that causes a prescription drug to not be covered until the step therapy requirement is satisfied or not to be covered as the prescribed number of doses.

(b) (1) A covered person or enrollee, or his/her authorized representative, may only file a written request under this section if the prescribing provider has determined that the requested prescription drug is medically necessary to treat the covered person or enrollee's disease or medical condition because:

- (A) There is no prescription drug listed on the formulary that is a clinically acceptable alternative to treat the covered person or enrollee's disease or medical condition;
- (B) The prescription drug alternative listed on the formulary in accordance with step therapy requirements:
 - (i) Has been ineffective in the treatment of the covered person or enrollee's disease or medical condition or, based on clinical, medical, and scientific evidence and the known relevant physical or mental characteristics of the covered person or enrollee and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
 - (ii) Has caused or, based on clinical, medical, and scientific evidence, is likely to cause an adverse reaction or other harm to the covered person or enrollee; or
 - (iii) The covered person or enrollee was at the top level of a step therapy under another health plan, so that it would be unreasonable to start in a lower step therapy level.
- (C) The doses available under a dose restriction for the prescription drug has been ineffective in the treatment of the covered person or enrollee's disease or medical condition or, based on clinical, medical, and scientific evidence and the known relevant physical and mental characteristics of the covered person or enrollee and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

(2)(A) The health insurance organization or insurer may require the covered person or enrollee, or his/her authorized representative, to provide a written certification from the prescribing provider of the determination made under paragraph (1)

(B) the health insurance organization or insurer may require the written certification to include only the following information:

- (i) the name, group or contract number, subscriber number;
 - (ii) Patient history;
 - (iv) The primary diagnosis related to the requested prescription drug that is that is the subject of the medical exception request;
 - (v) The reason:
 - I. Why the formulary drug is not acceptable for the particular patient; or
 - II. If the medical exception request involves a step therapy requirement, why the prescription drug required is not acceptable for that particular patient; or
 - III. If the medical exception request involves a dose restriction, why the available number of doses for the prescription drug is not acceptable for that particular patient;
 - IV. The reason why the prescription drug that is the subject of the medical exception request is needed for the patient or, if the medical exception request involves a dose restriction, why an exception to the dose restriction is needed for that particular patient.
- (c) (1) Upon receipt of a medical exception request made pursuant to this section the health insurance organization or insurer shall ensure that the request is reviewed by appropriate healthcare professionals who, depending on the health condition for which the medical exception is requested, in reaching a decision on the request, shall take into account the specific facts and circumstances that apply to the covered person or enrollee for whom the request has been made using documented clinical review criteria that:
- (A) Are based on solid clinical, medical, and scientific evidence; and
 - (B) If available, appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, practice guidelines developed by the health insurance organization or insurer's Pharmacy and Therapeutics Committee, or any other practice guidelines developed by the Federal government or by national or professional medical or pharmacist societies, boards, and associations.
- (2) The healthcare professionals designated by the health insurance organization or insurer to review the medical exceptions request shall ensure that the decision reached on such request is consistent with the benefits and exclusions under the covered person or enrollee's health plan. The healthcare professionals designated to review medical exception requests shall have experience in the management of prescription drugs. Such determinations shall be duly stated in a report, which shall include the qualifications of the healthcare professionals who made such determination.
- (d) (1) The medical exceptions process under this Section shall require the health insurance organization or insurer to make a decision on a request made and provide notice of such

- decision to the covered person or enrollee, or his/her authorized representative, as quickly as the covered person or enrollee's particular medical condition requires, but in no event later than seventy-two (72) hours after the date of receipt of the request or, if required by the health insurance organization or insurer, the date of receipt of the certification under subsection b(2).
- (2) (a) If the health insurance organization or insurer fails to make a decision on the request and provide notice of the decision within the aforementioned time;
- (i) The covered person or enrollee shall be entitled to coverage for up to thirty-day's supply of the prescription drug that is subject of the request; and
- (ii) The health insurance organization or insurer shall make a decision on the medical exception request prior to the covered person or enrollee's completion of the supply.
- (b) If the health insurance organization or insurer fails to make a decision prior to the covered person or enrollee's completion of the supply, the health insurance organization or insurer shall maintain coverage on the same terms on an ongoing basis, as long as the prescription drug continues to be prescribed for the covered person or enrollee and is considered safe for the treatment of his/her disease or medical condition, unless the applicable benefit limits have been exhausted.
- (e) (1) Whenever a medical exception request made under this section is approved, the health insurance organization or insurer shall provide coverage for the prescription drug that is the subject of the request and not require the covered person or enrollee to request approval under this section for a refill or a new prescription to continue using the prescription drug after the refill for the initial prescription have been exhausted. All of the foregoing shall be subject to the terms of the prescription drug coverage under the health plan provided:
- (a) That the covered person or enrollee's prescribing provider continues to prescribe such prescription drug to treat the same disease or medical condition; and
- (b) The prescription drug continues to be considered safe for treating the covered person or enrollee's disease or medical condition.
- (2) The health insurance organization or insurer shall not establish a special formulary tier, co-payment, or other cost-sharing requirement that is applicable only to prescription drugs approved through medical exception requests.
- (f) (1) Any denial of a medical exception request made by a health insurance organization or insurer:
- (A) Shall be notified to the covered person or enrollee or, if applicable, to his/her authorized representative, in writing or electronically, if the covered person or enrollee has agreed to receive information in this manner;
- (B) Notified electronically to the prescribing provider or, upon request, in writing; and
- (C) May be appealed by filing a grievance pursuant to the chapter on Health Insurance Organization or Insurer Grievance Procedures.
- (2) The denial shall, in a manner that is comprehensible to the covered person or enrollee or, if applicable, his/her authorized representative, set forth:

- (A) The specific reasons for the denial.
 - (B) A reference to the evidence or documentation, including the clinical review criteria practice guidelines, and clinical, medical, and scientific evidence considered in reaching the decision to deny the request.
 - (C) Instructions for requesting a written statement of the clinical, medical, or scientific rationale for the denial; and
 - (D) A description of the process and procedures that must be followed for filing a grievance to appeal the denial pursuant to the chapter on Health Insurance Organization or Insurer Grievance Procedures, including any time limits applicable to those procedures.
- (g) A health insurance organization or insurer shall not be required to establish a medical exception request process or to comply with the provisions of subsection b,c,d,e(1), and f if such health insurance organization or insurer;
- (1) Has expedited utilization review process; and
 - (2) Allows covered persons or enrollees, or their authorized representatives, to use this process to seek approval for coverage of a prescription drug that is not covered because of formulary or other management process.
- (h) Nothing in this section shall be construed to allow a covered person or enrollee to use the medical exception process set forth in this section to request coverage for a prescription drug that is categorically excluded from coverage under his/her health plan.

Section 1936. Record Keeping and Reporting Requirements.

- (a) Each health insurance organization or insurer shall maintain sufficient written or electronic records to demonstrate compliance with this subchapter, including records documenting the process for making decisions on formularies and other prescription drug management processes and records documenting the application of the medical exception request process. The records shall be maintained for a period of five (5) years or until the completion of the health insurance organization or insurer's next market conduct examination, whichever is later, and shall be made available to the Commissioner upon request.
- (b) Each health insurance organization or insurer shall maintain data on and make available to the Commissioner upon request the following information with respect to medical exception requests:
- (1) The total number of medical exception requests;
 - (2) From the total number of medical exception requests provided under paragraph (1):
 - (A) The number of requests made for coverage of a nonformulary prescription drug;
 - (B) The number of requests made for an exception to a management process that subjects a prescription drug to dose restrictions or step therapy requirements;
 - (3) The number of medical exceptions requests approved and denied; and
 - (4) Any other information that the Commissioner may request.

Section 1937. Oversight and Contracting Responsibilities.

- (a) A health insurance organization or insurer shall be responsible for the oversight of all activities carried out under the subchapter and for ensuring that all the requirements thereof and applicable regulations are met.
- (b) If a health insurance organization or insurer contracts with another person to carry out activities required under this subchapter or applicable regulations, the Commissioner shall hold the health insurance organization or insurer responsible for the activities of the contracted person and for ensuring that the requirements of this subchapter and applicable regulations with respect to such activity are met.

Section 1938. Disclosure Requirements.

- (a) Each health insurance organization or insurer that uses a formulary or any other prescription drug management process shall, in the policy, certificate, membership booklet, outline of coverage, evidence of coverage, or any other document provided to a covered person or enrollee;
 - (1) Disclose the existence of the formulary and any other management processes and the fact that there may be other plan restrictions or requirements that may affect the specific prescription drugs that will be covered;
 - (2) Describe the medical exception process that may be used to request coverage of nonformulary prescription drugs or to obtain an exception to dose restriction or step therapy requirements; and
 - (3) Describe the process for filing a grievance, as set forth in the subchapter on Health Insurance Organization or Insurer Grievance Procedure, to appeal a denial of a medical exception request.
- (b) The policy, certificate, membership booklet, outline of coverage, evidence of coverage or any other document provided to covered persons or enrollees shall explain, in layperson's terms, the information on the health insurance organization or insurer's formulary and each prescription drug management process. Such explanation shall also state that the health insurance organization or insurer shall provide covered persons or enrollees with a copy of the formulary and information about which prescription drugs are subject to a management process.

Section 1939. Maintenance Drugs

When the history of the covered person or enrollee so requires, insofar as it does not jeopardize the patient's health, and at the discretion of the healthcare provider, such healthcare provider may prescribe refills for maintenance drugs up to a term that shall not exceed one hundred eighty (180) days, subject to the health insurance plan's coverage.

Chapter II.III. Health Insurance Organizations or Insurers Claim Audits

Section 1940. Short Title.

This Subchapter shall be known and may be cited as the Subchapter on Health Insurance Organizations or Insurers Claim Audit.

Section 1941. Purpose.

The purpose of this subchapter is to provide for the standardization of claim audit of bills for healthcare services presented to health insurance organizations or insurers, third party administrators, or any other health insurance plans. Such audits shall be carried out to determine whether data in a healthcare record of a provider is supported by services listed on the claim for payment of an enrollee or a provider. It is also intended to alleviate the potential conflict of the audit with medical uses of the health record and to reduce the cost entailed by unnecessary audits.

Section 1943. Definitions.

For purposes of this Chapter:

- (a) “Qualified Claim Auditor” means a person employed or hired by a health insurance organization or insurer that is recognized as competent to perform or coordinate claim audits and that abides by policies and procedures geared to protect the confidentiality and properly manage all patient information in his/her possession.
- (b) “Claim Audit” means a process to determine whether data in a claimant’s medical record documents healthcare services listed on a claim for payment submitted to a health insurance organization or insurer. Claim audit does not mean a review of the medical necessity of the services provided, or the reasonableness of charges for the services.
- (c) “Overcharges” or “Unsupported Charges” means the volume of services indicated on a claim exceeds the total volume identified in the provider’s medical documentation.
- (d) “Unbilled Charges” means charges or services provided for and not billed.
- (e) “Underbilled Charges” means the volume of services indicated on a claim is less than the volume identified in the provider’s documentation.
- (f) “Ambulatory Surgical Center” means an establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures. Such centers provide continuous physician services and registered nursing services whenever a patient is in the center. An Ambulatory surgical center does not provide services for patients to stay overnight, but provide the following services for patients to stay overnight, but provide the following services whenever a patient is in the center:
 - (1) drug services as needed for medical operations performed;
 - (2) provisions for physical and emotional well-being of patient;
 - (3) emergency services;
 - (4) administrative structure; and
 - (5) administrative, statistical and medical records.
- (g) “Medical Record” means a compilation of charts, records, reports, documents, and other memoranda maintained by a provider wherever located, to record or indicate the

- present, past, or prospective physical or mental conditions, sickness, or disease of a patient and treatment rendered,
- (h) “Provider” means healthcare professional or healthcare facility duly authorized to render or provide healthcare services.
 - (i) “Final Claim” means the final itemized bill from a provider detailing all the charges for which the provider is seeking payment.
 - (j) “Claimant” means a covered person or enrollee under a health plan who has received healthcare services, the costs of which are submitted to a health insurance organization or insurer for payment, either by the claimant or by another on the claimant’s behalf.

Section 1943. Applicability and Scope.

This subchapter shall apply to all health insurance organizations or insurers. The provider accepting payment of benefits of a covered person or enrollee shall be responsible for the conduct and results of the claim audit whether conducted by an employee or by contract with another firm. The provider and health insurance organization or insurer shall:

- (a) Supervise the process to ensure that the audit is conducted in accordance with the requirements of this subchapter;
- (b) Be aware of the actions being undertaken by the auditor in connection with the claim audit; and
- (c) Take prompt remedial action if inappropriate behavior by the auditor is discovered.

Section 1944. Qualifications of Auditors and Provider Audit Coordinators.

- (a) Claim auditors and provider audit coordinators shall have appropriate knowledge, experience, and expertise in the field of healthcare including, but not limited to, the following areas:
 - (1) Format and content of the health record as well as other forms of medical and clinical documentation;
 - (2) Generally accepted auditing principles and practices as they apply to claim audits;
 - (3) Billing claims forms in effect in the health insurance industry and billing procedures;
 - (4) All federal and Virgin Islands regulations concerning the use, disclosure and confidentiality of patient records;
 - (5) Specific critical care units, specialty area and ancillary units involved in a particular audit; and
 - (6) Medical terminology and coding, including ICD-9, CPT, HCPCS.
- (b) If a provider or health insurance organization or insurer finds that audit personnel do not meet these qualifications shall immediately contact the auditor’s firm or sponsoring party.
- (c) Audit Personnel shall conduct themselves in a professional manner and adhere to ethical standards and confidentiality requirements, and shall remain objective. They shall be required to completely document their findings and problems.

- (d) All unsupported, unbilled or underbilled charges identified in the course of an audit shall be documented in the audit report by the auditor.
- (e) Individual audit personnel shall not be placed in a situation through their remuneration, benefits, fees or other instructions that would call their findings into question. Compensation of audit personnel shall be structured so that it does not create incentives to produce questionable audit findings. Providers or health insurance organizations or insurers that encounter an individual who appears to have a conflict of interest shall contact the appropriate officers of the organization conducting the audit.

Section 1945. Notice of Audit.

- (b) Health insurance organizations or insurers and providers shall make every effort to resolve claim inquiries directly. The name, contact telephone number, and fax number of each representative of the health insurance organization or insurer or the provider shall be exchanged no later than at the time of billing for a provider and the point of first inquiry by health insurance organization or insurer.
- (c) If a satisfactory resolution of the questions surrounding the bill is not achieved by the representatives of the health insurance organization or insurer and the provider, then a full audit process may be initiated by the health insurance organization or insurer.
- (d) Claim audits may require documentation from or review of a patient's medical record and other similar medical or clinical documentation. Medical records exist primarily to ensure continuity of care for a patient. Therefore, the use of a patient's record for an audit must be secondary to use in patient care.
- (e) All health insurance organization or insurer claim audits shall begin with a notification to provider of an intent to audit. Notification to the provider by the qualified claim auditor shall occur within six (6) months following receipt of the final claim for payment by the health insurance organization or insurer. Once notified, the provider shall respond to the qualified claim auditor within (30) days with a schedule for the conduct of the audit. The qualified auditor shall complete the audit within thirty-six (36) months of receipt of the final claim by the health insurance organization or insurer. Each party shall make reasonable provisions to accommodate circumstances in which the schedule specified cannot be met by the other party. The health insurance organization or insurer shall not request nor accept audits after thirty-six (36) months from the date of receipt of the final claim. Provided, that it shall not be construed that the thirty-six (36) month term provided to complete the audit shall render ineffective shorter terms that have been agreed on for the same purpose under a contract.
- (f) All claims audits shall be conducted on the premise of the provider, except in instances where a provider, except in instances where a provider chooses to allow individual, reasonable requests for off-site audits.
- (g) All requests for claim audits, whether telephonically, electronically or written, shall include the following information:

- (1) The basis of the health insurance organization or insurer's intent to conduct an audit on a particular bill or portions of the bills. When the intent is to audit only specific charges or portions of the bills, this information should be included in the notification;
 - (2) Name of the patient;
 - (3) Admit and discharge date, if apply;
 - (4) Name of the auditor and the name of the audit firm, if the health insurance organization or insurer has contracted with a third party to conduct the audit;
 - (5) Medical record number and the provider's patient account number, if known; and
 - (6) Whom to contact to discuss the request and schedule audit.
- (h) Providers that cannot accommodate an audit request that conforms to these provision, shall explain, within a term that shall not exceed thirty (30) days, why the request cannot be met. Along with the explanation, providers shall propose a new date to reschedule the audit, which shall not exceed sixty (60) days as of the date of the original audit. Auditors shall group audits to increase efficiency whenever possible.
- (i) It shall be the responsibility of the provider seeking payment of a claim or reimbursement to notify the auditor prior to the scheduled date of audit, if the auditor shall have problems accessing records. The provider shall be responsible for supplying the auditor with any information that could affect the efficiency of the audit once the auditor is on-site.

Section 1946. Provider Audit Coordinators

- (a) Providers shall designate an individual to coordinate all claim audit activities. An audit coordinator shall have the same qualification as required for an auditor pursuant to Section 1944 of this subchapter. The duties of an audit coordinator include, among others, the following:
- (1) Scheduling an audit;
 - (2) Advising other provider personnel and departments of a pending audit;
 - (3) Ensuring that the condition of admission statement is part of the medical record;
 - (4) Verifying that the auditor is an authorized representative of the health insurance organization or insurer;
 - (5) Gathering the necessary documents for the audit;
 - (6) Coordinating auditor requests for information, space in which to contact an audit, and access to records and provider personnel;
 - (7) Orienting auditors with respect to the provider's audit procedures, record documentation conventions, and billing practices;
 - (8) Acting as a liaison between the auditor and other personnel of the provider;
 - (9) Conducting an exit interview with the auditor to answer questions and review audit finding;
 - (10) Reviewing the auditor's final written report and following up on any charges still in dispute;
 - (11) Arranging for payment as applicable; and
 - (12) Arranging for any required adjustment to bills or refunds.

Section 1947. Conditions and Scheduling of Audits.

- (a) In order to have a fair, efficient and effective audit process, providers and health insurance organization or insurer' auditors shall adhere to the following requirements:
 - (1) Whatever the original intended purpose of the claim audit, all parties shall agree to recognize, record or present any identified unsupported, unbilled or underbilled charges discovered by the audit parties;
 - (2) The scheduling of an audit shall not preclude late billing;
 - (3) The parties involved in the audit shall mutually agree to set a time frame for the resolution of any discrepancies, questions or errors that surface in the audit;
 - (4) An exit conference and a written report shall be part of each audit. If the provider waives the exit conference, the auditor shall note that action in the written report. The specific content of the final report shall be restricted to those parties involved in the audit;
 - (5) The provider shall be afforded sixty (60) days to contest all findings, after which the audit shall be considered final;
 - (6) Once both parties agree to the audit findings, audit results are final;
 - (7) All personnel involved shall maintain a professional, courteous manner and resolve all misunderstandings amicably; and
 - (8) If the auditor notes ongoing problems either with the billing or documentation process and it cannot be corrected as part of the exit process, the management of the provider and health insurance organization or insurer shall be contacted to apprise them of the situation. The provider and health insurance organization or insurer shall take appropriate steps to resolve the identified problem. Parties to an audit shall eliminate ongoing problems or questions whenever possible as part of the audit process.

Section 1948. Confidentiality and Authorizations.

- (a) All parties to a claim audit shall comply with all federal and Virgin Islands laws and contractual agreements regarding the confidentiality of patient information.
- (b) The release of medical records requires authorization from the patient. An authorization shall be provided for in the condition of admission or equivalent statement procured by the provider upon admission of the patient. If no such statement is obtained, an authorization for a claim audit is required. The authorization for a claim audit is required. The authorization need not be specific to the health insurance organization or insurer or auditor conducting the audit.
- (c) The authorization shall be obtained by the claim audit firm or provider and shall include at least the following information:
 - (1) The name of the health insurance organization or insurer and, if applicable, the name of the audit firm that is to receive the information;
 - (2) The name of the institution that is to release the information;
 - (3) The full name, birth date, and address of the patient whose records are to be released;

- (4) The extent or nature of the information to be released, with inclusive dates of treatment;
 - (5) The provider's patient account number, if included on the bill; and
 - (6) The signature of the patient or his/her legal representative and the date the consent is signed.
- (d) A patient's assignment of benefits shall include a presumption of authorization to review records.
- (e) The audit coordinator shall confirm for the audit representative that a condition of admission statement is available for the particular audit that needs scheduling.
- (f) The provider shall inform the patient or requestor, on a timely basis, if there are any Federal or Virgin Islands laws prohibiting or restricting review of the medical record and if there are institutional confidentiality policies and procedures that affect the review of such documents. These institutional confidentiality policies shall not be specifically oriented in order to delay an external audit.

Section 1949. Documentation.

- (a) Verification of charges shall include the investigation of whether or not:
- (1) Charges are reported on the bill accurately;
 - (2) Services are documented in medical or other records as having been rendered to the patient; and
 - (3) Services were delivered in accordance with the physician's plan of treatment. In appropriate situations, professional staff may provide supplies or follow procedures that are in accordance with established institutional policies, procedures, or professional licensure standards. Many procedures include items that are not specifically documented in a record but are referenced in medical or clinical policies. All those policies shall be reviewed, approved, and documented as required by the Joint Commission on Accreditation of Healthcare Organizations or other accreditation agencies. Policies shall be available for review by the auditors.
- (b) The medical record documents clinical data on diagnosis, treatments and outcomes, and is not designed to be a billing document. A patient medical record generally documents pertinent information related to care and does not back up each individual charge on the patient bill. Other signed documentation for services provided to the patient may exist within the provider's ancillary departments in the form of department treatment logs, daily records. Individual service or order tickets and other documents.
- (c) Auditors may have to review a number of other documents to determine valid charges and must recognize that these sources of information are accepted as reasonable evidence that the services ordered by the physician were actually provided to the patient. Providers must ensure that proper policies and procedures exist to specify what documentation and authorization must be in the medical record and the ancillary records and logs. Furthermore, these procedures shall document that services have been properly ordered for and delivered to patients. When sources other than the medical record are providing documentation, the provider shall notify the auditor and make those sources available to the auditor.

Section 1950. Fees and Payments

- (a) A health insurance organization or insurer shall make prompt payment of a bill in accordance with the provision of section 1725 of this title and shall not delay payment for an audit process. Payment on a submitted bill from a third-party shall be based on amounts billed and covered by the patient's health plan.
- (b) Audit fees shall be paid upon commencement of the claim audit.
- (c) A payment identified in the audit results that is owed to either party by the other, shall be settled by the audit parties within a reasonable period of time not to exceed thirty (30) days after completion of the audit unless the parties agree otherwise.

Chapter II.V. Health Insurance Organization or Insurer Grievance Procedure

Section 1951. Title.

This subchapter shall be known and may be cited as the subchapter on Health Insurance Organization or Insurer Grievance Procedure.

Section 1952. Purpose.

The purpose of this subchapter is to provide standards for the establishment and maintenance of procedures by health insurance organizations and insurers to ensure that covered persons or enrollees have the opportunity for the appropriate resolution of grievances, as defined in this subchapter.

Section 1953. Definitions.

For purposes of this subchapter:

- (a) "Certification" means a document that contains a determination by a health insurance organization or insurer, or a utilization review organization, that a request for a benefit under a health plan has been reviewed and, based on the information provided, satisfies the health insurance organization or insurer's requirements for medical necessity, appropriateness, healthcare setting, level of care and effectiveness,
- (b) "Adverse Determination" means:
 - (1) A determination by a health insurance organization or insurer, or a utilization review organization that, based upon the information provided, a request for a benefit under a health plan, upon application of any utilization review technique, does not meet the health insurance organization or insurer's requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness, or is determined to be experimental or investigational, and the requested benefit is therefore denied, reduced, or terminated, or payment is not provided or made, in whole or in part. For such benefit.
 - (2) The denial, reduction, termination, or failure to make payment, in whole or in part, for a benefit based on a determination by a health insurance organization or insurer, or a utilization review organization, of a covered person or enrollee's eligibility to participate in the health plan; or

- (3) Any prospective review or retrospective review determination that denies, reduces, or terminates, or fails to make payment, in whole or in part, for a benefit.
- (c) “Stabilized” means, with respect to an emergency medical condition, that no deterioration of the condition of the patient is likely, within reasonable medical probability, before the transfer of such individual from a facility
- (d) “Clinical Peer” means a physician or other healthcare professional, who holds a non-restricted license in a state of the United States or in Virgin Islands, and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.
- (e) “Case Management” means a coordinated set of activities established by a health insurance organization or insurer and conducted for individual patient management of serious, complicated, protracted, or other health conditions.
- (f) “Utilization Review Organization” means an entity contracted by a health insurance organization or insurer to conduct utilization review when such health insurance organization or insurer does not perform utilization review for its own health plan. It shall not be construed as a requirement for health insurance organizations or insurers to subcontract an independent entity to carry out utilization review processes.
- (g) “Discharge Planning” means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.
- (h) “Grievance” means a written complaint or an oral complaint if the complaint involves an urgent care request, submitted by or on behalf of a covered person or enrollee regarding:
- (1) Availability, delivery, or quality of healthcare services, including complaints regarding an adverse determination made pursuant to utilization review;
 - (2) Claims payment, handling, or reimbursement for healthcare services; or
 - (3) Matters pertaining to the contractual relationship between a covered person or enrollee and a health insurance organization or insurer.
- (i) “Network” means the group of participating providers providing services to a managed care plan.
- (j) “Concurrent Review” means utilization review conducted during a patient’s stay or course of treatment in a facility, the office of a healthcare professional, or other inpatient healthcare setting.
- (k) “Ambulatory Review” means utilization review of healthcare services performed or provided in an outpatient setting.
- (l) “Utilization Review” means a set of formal techniques designed to monitor healthcare services, procedures, or facilities or to evaluate the medical necessity, appropriateness, efficacy, or efficiency thereof. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.
- (m) “Prospective Review” means utilization review conducted prior to providing a healthcare service or a course of treatment, in accordance with a health insurance

organization or insurer's requirement that such healthcare service or course of treatment, in whole or in part, be approved prior to carrying out the service or course of treatment.

- (n) "Retrospective Review" means any review of a request for a benefit that is not a prospective review request. "Retrospective Review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.
- (o) "Second Opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed healthcare service to assess the medical necessity and appropriateness of such initial proposed healthcare service.
- (p) "Urgent Care Request" means:
 - (1) A request for a healthcare service or course of treatment with respect to which the time period for making a non-urgent care request determination:
 - (a) Could seriously jeopardize the life or health of the covered person or enrollee or his/her ability to regain maximum function; or
 - (b) In the opinion of an attending healthcare professional with knowledge of the covered person or enrollee's medical condition, would subject said covered person or enrollee to severe pain that cannot be adequately managed without the healthcare service or treatment that is the subject of the request.
 - (2) In determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health insurance organization or insurer shall apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Any request that an attending healthcare professional with knowledge of the covered person or enrollee's medical condition determines is an urgent care request within the meaning of paragraph (1) shall be treated as an urgent care request.

Section 1954. Applicability and Scope.

Except as otherwise specified, this subchapter shall apply to all health insurance organizations or insurers.

None of the provisions of this subchapter shall limit or in any way impair the legal powers of the Commissioner of Insurance or its designee to initiate, investigate, process, or adjudicate new or pending grievances. None of the provisions of this chapter shall be construed to amend or repeal the laws, regulations, or procedures of the Commissioner or its designee.

Section 1955. Requirements to Report Grievances to the Commissioner.

- (a) Health insurance organizations or insurers shall maintain written records to document all grievances received during a calendar year (the register).
- (b) A request for a first level review of a grievance involving an adverse determination shall be processed in compliance with section 1957. A request for a standard review

- of a grievance not involving an adverse determination shall be processed in compliance with section 1958.
- (c) A request for an additional voluntary review of a grievance shall be processed in compliance with section 1959.
 - (d) For each grievance, the register shall contain at least the following information:
 - (1) A general description of the reason(s) for the grievance;
 - (2) The date received;
 - (3) The date of each review or, if applicable, review meeting;
 - (4) Decision/resolution at each level of the grievance, if applicable;
 - (5) Date of decision/resolution at each level, if applicable; and
 - (6) Name of the covered person or enrollee for whom the grievance was filed.
 - (e) The register shall be maintained in a manner that is clear and accessible to the Commissioner.
 - (f) (1) Health insurance organizations or insurers shall retain the register compiled for a calendar year for the longer of five (5) years or until the Commissioner has issued a final report of an examination that contains a review of the register for that calendar year.
 - (3) (a) Health insurance organizations or insurers shall submit to the Commissioner, at least annually, a report in the format specified by him/her.
 - (b) The report shall include the following for each type of health plan offered by the health insurance organization or insurer:
 - (i) The certificate of compliance required by section 1956(c);
 - (ii) The number of covered persons or enrollees;
 - (iii) The total number of grievances for which a covered person or enrollee requested and additional voluntary grievance review pursuant section 1963.
 - (vi) The number of grievances appealed to the Commissioner of which the health insurance organization or insurer has been informed;
 - (vii) The number of grievances referred to alternative dispute resolution procedures, such as mediation or arbitration, or resulting in litigation; and
 - (viii) A synopsis of actions taken to correct the problems identified.

Section 1956. Grievance Review Procedures

- (a) Except as specified in section 1960, health insurance organizations or insurers shall receive and resolve grievances from covered persons or enrollees as provided in sections 1957, 1958, 1959.
- (b) Health Insurance organizations or insurers shall file a copy of the procedures required under subsection (a), including all forms used to process the requests made with the Commissioner. Any subsequent modifications to such procedures shall also be filed. The Commissioner may disapprove a filing received if it fails to comply with this Subchapter or the applicable regulations.

- (c) In addition to the provisions of subsection (b), health insurance organizations or insurers shall file annually with the Commissioner, as part of the annual report required by section 1955, a certificate of compliance stating that such health insurance organizations or insurers have established and maintain, for each of their health plans, grievance procedures that fully comply with the provisions of this subchapter.
- (d) A description of the grievance procedures required under this section shall be included in the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons or enrollees.
- (e) The grievance procedures included in the aforementioned documents shall include a statement of a covered person or enrollee's right to contact the Commissioner of Insurance for assistance at any time. The statement shall include the telephone number and address of the Division of Banking and insurance.

Section 1957. First Level Reviews of Grievances involving an Adverse Determination

- (a) Within one hundred eighty (180) days after the receipt of a notice of an adverse determination, a covered person or enrollee, or his/her authorized representative, may file a grievance with the health insurance organization or insurer requesting a first level review of the adverse determination.
- (b) The health insurance organization or insurer shall provide the covered person or enrollee with the name, address, and telephone number of a person or organization designated to coordinate the first level review on behalf of the health insurance organization or insurer.
- (c) (1) (A) If the grievance arises from an adverse determination involving utilization review, the health insurance organization or insurer shall designate one or more clinical peers of the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The designated clinical peer(s) shall not have been involved in the initial adverse determination.
 - (B) The health insurance organization or insurer shall ensure that, if more than one clinical peer is involved in the review, they have appropriate expertise.
- (2) In conducting a review under this section, the reviewer(s) shall take into consideration all comments, documents, records, and other information regarding the request for services submitted by the covered person or enrollee, or his/her authorized representative, without regard to whether the information was submitted or considered in making the initial adverse determination.
- (d) (1) (A) The covered person or enrollee or, if applicable, his/her representative shall be entitled to:
 - (i) Submit written comments, documents, records, and other material related to the grievance under review; and
 - (ii) Receive from the health insurance organization or insurer, upon request and free of charge, access to and copies of all documents, record, or other information:
 - (B) For purposes of subparagraph (A) (ii), a document, record or other information shall be considered relevant to a grievance if the document, record, or other information:

- (i) Was relied upon in making the benefit determination;
- (ii) Was submitted, considered, or generated in the course of making the adverse determination, without regard to whether the document, record, or other information was relied upon in making the benefit determination;
- (iii) Demonstrates that, in making the benefit determination, the health insurance organization or insurer consistently applied the same administrative procedures and safeguards with respect to the covered person or enrollee as other similarly situated covered persons or enrollees; or
- (iv) Constitutes a statement of policy or guidance with respect to the health plan concerning the denied healthcare service or treatment for or guidance was relied upon in making the initial adverse determination.

(2) The health insurance organization or insurer shall make the provisions of paragraph (1) known to the covered person or enrollees or, if applicable, his/her authorized representative, within three (3) working days after the date of receipt of the grievance.

(e) For purposes of calculating the time periods within which a determination is required to be made and notice provided under subsection (f), the time period shall begin on the date the grievance is filed with the health insurance organization or insurer, without regard to whether all of the information necessary to make the determination accompanies such filing. If the health insurance organization or insurer understands that the grievance does not include all the necessary information to make a determination, it shall clearly indicate the covered person or enrollee or, if applicable, his/her authorized representative, the reasons for which it cannot process such grievance and the additional documents or information that the covered person or enrollee must provide.

(f) (1) Health insurance organizations or insurers shall notify and issue a decision in writing, or electronically if the covered person or enrollee or, if applicable, his/her authorized representative, has agreed to be thus notified, within the timeframes provided in paragraph (2) or (3).

(2) With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, the health insurance organization or insurer shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person or enrollee's medical condition, but no later than fifteen (15) calendar days after the receipt of the grievance.

(3) With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, the health insurance organization or insurer shall notify and issue a decision within a reasonable period of time, but not later than thirty (30) calendar days after the receipt of the grievance.

(g) The decision issued pursuant to subsection (f) shall set forth in a manner that is comprehensible to the covered person or enrollee or, if applicable, his/her authorized representative:

(1) The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);

(2) A statement of the reviewers' understanding of the covered person or enrollee's grievance;

(3) The reviewers' decision in clear terms and the contract basis or medical rationale for the covered person or enrollee or, if applicable, his/her authorized representative, to respond to the health insurance organization or insurer's position;

(4) The evidence or documentation used as the basis for the decision;

(5) In the event that the health insurance organization or insurer's first level review decision results in adverse determination, the following shall also be included:

(A) The specific reasons for the adverse determination;

(B) The reference to the specific health plan provisions on which the determination is based;

(C) A statement that the covered person or enrollee is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant, as the term "relevant" is defined in subsection (d)(1)(B);

(D) If the health insurance organization or insurer relied upon an internal rule, guideline, protocol, or other similar criterion to make the final adverse determination, a copy of such rule, guideline, protocol, or other similar criterion in which the final adverse determination was based shall be provided, upon request and free of charge, to the covered person or enrollee or, if applicable, his/her authorized representative;

(E) If the final adverse determination is based on a medical necessity, experimental or investigational treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination or a statement that an explanation shall be provided, upon request and free of charge, to the covered person or enrollee or, if applicable, his/her authorized representative; and

(F) If applicable, instructions for requesting:

(i) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the final adverse determination, as provided in subparagraph (5)(D); and (ii) A written statement of the scientific or clinical rationale for the determination, as provided in subparagraph (5)(E).

(6) If applicable, a statement indicating:

(A) A description of the process to obtain an additional voluntary review of the covered person or enrollee wishes to request a voluntary review pursuant to section 1961.

(B) The written procedure governing the voluntary review, including any required timeframe for the review;

(C) A description of the procedures for obtaining an independent external review, pursuant to this subchapter on Health Insurance Organization or Insurer External Review, if the covered person or enrollee decides not to file for an additional voluntary review; and

(D) The covered person or enrollee's right to bring a civil action in a court of competent jurisdiction;

(7) If applicable, and stressing its voluntary nature, the following statement: "You and your health plan may have other voluntary alternative dispute resolution options, such as mediation or arbitration. One way to find out what may be available is to contact the Commissioner of Insurance"; and

(8) A statement of a covered person or enrollee's right to contact the Office of the Commissioner of Insurance at any time, including the telephone number and address of the Division of Banking and Insurance.

Section 1958. Standard Reviews of Grievances Not Involving an Adverse Determination

(a) Health insurance organizations or insurers shall establish written procedures for standard reviews of grievances that do not involve an adverse determination.

(b) (1) The procedure shall permit a covered person or enrollee, or his/her authorized representative, to file a grievance that does not involve an adverse determination with the health insurance organization or insurer under this section.

(2) (A) A covered person or enrollee, or his/her authorized representative, shall be entitled to submit written material for the persons designated by the health insurance organization or insurer to consider when conducting the standard review.

(B) The health insurance organization or insurer shall notify, the covered person or enrollee or, if applicable, his/her authorized representative, of such covered person or enrollee's right pursuant to subparagraph (2)(A) within three (3) business days after receiving the grievance.

(c) (1) Upon receipt of the grievance, a health insurance organization or insurer shall designate one or more persons to conduct the standard review.

(2) To conduct the standard review of the grievance, the health insurance organization or insurer shall not designate the same person that handled the matter that is the subject of such grievance.

(3) The health insurance organization or insurer shall provide the covered person or enrollee or, if applicable, his/her authorized representative, with the name, address, and telephone number of the persons designated to conduct the standard review.

(d) The health insurance organization or insurer shall provide written notification of the decision to the covered person or enrollee or, if applicable, his/her authorized representative, within thirty (30) calendar days after the receipt of the grievance.

(e) The written decision issued pursuant to subsection (d) shall contain:

(1) The titles and qualifying credentials of the persons participating in the standard review process (the reviewers);

(2) A statement of the reviewers' understanding of the grievance;

(3) The reviewers' decision in clear terms and the contract basis or medical rationale for the covered person or enrollee to respond to the health insurance organization or insurer's position;

(4) A reference to the evidence or documentation used as the basis for the decisions;

(5) If applicable, a written statement including:

(A) A description of the process to obtain an additional voluntary review if the covered person or enrollee wishes to request a voluntary review pursuant to section 1959; and

(B) The written procedures governing the voluntary review, including any required timeframe for the review; and

(6) A statement of the covered person or enrollee's right to contact the Commissioner of Insurance for assistance at any time, including the telephone number and address of the Division of Banking and Insurance.

Section 1959. Voluntary Level of Reviews of Grievances

(a) (1) A health insurance organization or insurer that offers managed care plans shall establish a voluntary review process for its managed care plans to give those covered persons or enrollees who are dissatisfied with the first level review decision made pursuant to section 1957, or who are dissatisfied with the standard review decision made pursuant to section 1958, the option to request an additional voluntary review, at which they shall be entitled to appear before the designated representatives of the health insurance organization or insurer.

(2) This Section shall not apply to health indemnity plans

(b) (1) A health insurance organization or insurer required by this Section to establish a voluntary review process shall provide covered persons or enrollees, or their authorized representatives, with a notice pursuant to section 1957(g)(6) or section 1958(e)(5), as

appropriate. Such notice shall indicate the option to file a request for an additional voluntary review.

(2) Upon receipt of a request for an additional voluntary review, the health insurance organization or insurer shall send notice to the covered person or enrollee or, if applicable, his/her authorized representative, if the covered person or enrollee's right to:

(A) Request, within the timeframe specified in paragraph (3)(a), the opportunity to appear in person before a review panel of the health insurance organization or insurer's designated representatives;

(B) Receive from the health insurance organization or insurer, upon request, copies of all documents, records, and other information that is not confidential or privileged, related to the covered person or enrollee's request for an additional voluntary review;

(C) Present the covered person or enrollee's case to the review panel;

(D) Submit written comments, documents, records, and other material related to the request for an additional voluntary review for the review panel to consider both before and during the review meeting, if applicable;

(E) If applicable, ask questions to any representative of the health insurance organization or insurer on the review panel; and

(E) Be assisted or represented by an individual of the covered person or enrollee's choice, including an attorney.

(3) (A) A covered person or enrollee, or his/her authorized representative, who wishes to appear in person before the review panel shall make a written request to the health insurance organization or insurer not later than fifteen (15) business days after the receipt of the notice sent in accordance with paragraph (2).

(B) The covered person or enrollee's right to a fair review shall not be made conditional on such covered person or enrollee's appearance at the review.

(c) (1) (A) With respect to a request for voluntary review of a decision made pursuant to section 1959, a health insurance organization or insurer shall appoint a review panel to review the request.

(B) In conducting the review, the review panel shall take into consideration all comments, documents, records and other information regarding the request for an additional voluntary review submitted by the covered person enrollee, or his/her authorized representative, without regard to whether the information was submitted or considered in making the first level review decision.

(C) The panel shall have the legal authority to bind the health insurance organization or insurer to the panel's decision. If, after twenty (20) calendars days, the health

insurance organization or insurer fails to comply with the decision of the review panel, the latter shall notify such fact to the Commissioner.

(2) (A) Except as provided in subparagraph (2)(B), a majority of the panel shall be comprised of employees or representatives of the health insurance organization or insurer who were not involved in the standard review conducted pursuant to section 1958.

(B) An individual who was involved in the first level review decision may be a member of the panel or appear before the same to present information or answer questions.

(c) The health insurance organization or insurer shall ensure that the individuals conducting the additional voluntary review are healthcare professionals with the appropriate expertise.

(d) The individuals conducting the additional voluntary review shall not:

(i) Be a provider in the covered person or enrollee's health plan;

(ii) Have a financial interest in the outcome of the review.

(d) (1) (a) With respect to a request for an additional voluntary review of a decision made pursuant to section 1959, a health insurance organization or insurer shall appoint a review panel to review the request.

(b) The panel shall have the legal authority to bind the health insurance organization or insurer to the panel's decision. If, after twenty (20) calendar days, the health insurance organization or insurer fails to comply with the decision of the review panel, the latter shall notify such fact to the Commissioner.

(2) (a) Except as provided in subparagraph (2)(b), a majority of the panel shall be comprised of employees or representatives of the health insurance organization or insurer who were not involved in the standard review conducted pursuant to Section 1959.

(b) An employee or representative of the health insurance organization or insurer who participated in the standard review may be a member of the panel or appear before the same to present information or answer questions.

(e) (1) (A) Whenever a covered person or enrollee, or his/her authorized representative, requests, within the time frame specified in subsection (c) or (d), to appear in person before the review panel, the procedures for conducting the additional voluntary review shall be governed by the provisions described hereinbelow.

(B) (i) The review panel shall schedule and hold a review not later than thirty (30) calendar days after the receipt of the request for an additional voluntary review.

(ii) The covered person or enrollee or, if applicable, his/her authorized representative, shall be notified in writing, at least fifteen (15) business days in advance, of the date of the review meeting.

- (iii) The health insurance organization or insurer shall not unreasonably deny a request for postponement of the review made by the covered person enrollee, or his/her authorized representative.
- (C) The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person or enrollee or, if applicable, his/her authorized representative.
- (D) In cases where a face-to-face meeting is not practical for geographic reasons, a health insurance organization or insurer shall offer the covered person or enrollee or, if applicable, his/her authorized representative, the opportunity to communicate with the review panel, at the health insurance organization or insurer's expense, by conference call, video conferencing, or other appropriate technology.
- (E) If the health insurance organization or insurer intends to have legal representation, such health insurance organization or insurer shall notify the covered person or enrollee or, if applicable, his/her authorized representative, at least fifteen (15) calendar days in advance of the date of the review meeting. It shall also notify the covered person or enrollee that he/she may obtain legal representation of his/her own.
- (F) The review panel shall issue a written decision, as provided in subsection (f), to the covered person or enrollee or, if applicable, his/her authorized representative, not more than ten (10) business days of completing the review meeting.
- (2) Whenever the covered person or enrollee or, if applicable, his/her authorized representative, does not request the opportunity to appear in person before the review panel, such panel shall issue a decision and notify it in writing or electronically (if it has been agreed to thus notify this decision) as provided in subsection (f), within forty-five (45) calendar days after the earlier of:
- (A) The date on which the covered person or enrollee or his/her authorized representative's opportunity to request to appear in person before the review panel expires, pursuant to subsection (b)(3)(A).
- (B) The date on which the covered person's or enrollee's or his/her authorized representative's opportunity to request to appear in person before the review panel expires, pursuant to subsection (b)(3)(A).
- (f) The written decision issued pursuant to subsection (e) shall include:
- (1) The titles and qualifying credentials of the members of the review panel;
 - (2) A statement of the review panel's understanding of the request for an additional voluntary review and all pertinent fact;
 - (3) The rationale for the review panel's decision;

(4) A reference to evidence or documentation considered by the review panel in making that decision;

(5) In cases concerning a request for an additional voluntary review involving an adverse determination:

(A) The instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and

(B) If applicable, a statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to this subchapter on Health Insurance Organization or Insurer External Review; and

(6) A statement of a covered person or enrollee's right to contact the Commissioner of Insurance for assistance at any time, including the telephone number and address of the Division of Banking and insurance.

Section 1960. Expedited Reviews of Grievances Involving an Adverse Determination.

- (a) Health insurance organizations or insurers shall establish written procedures for the expedited review of urgent care requests involving an adverse determination.
- (b) The procedures shall allow a covered person or enrollee, or his/her authorized representative, to request an expedited review under this section to the health insurance organization or insurer either orally or in writing.
- (c) A health insurance organization or insurer shall appoint an appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed to conduct the expedited review. Such clinical peers shall not have been involved in making the initial adverse determination.
- (d) In an expedited review, all the necessary information, including the health insurance organization or insurer's decision, shall be transmitted between the health insurance organization or insurer and the covered person or enrollee or, if applicable, his/her authorized representative, by telephone, fax, or the most expeditious method available.
- (e) An expedited review decision shall be made and the covered person or enrollee or, if applicable, his/her authorized representative, shall be notified of the decision in accordance with subsection (g) as expeditiously as the covered person or enrollee's medical condition requires, but in no event more than forty-eight (48) hours after the receipt of the request for the expedited review.
- (f) For purposes of calculating the time period within which a decision is required to be made and notified under subsection (e), the time period shall begin on the date the request for an expedited review is filed with the health insurance organization or insurer without regard to whether all of the information necessary to make the determination accompanies such filing.
- (g) (1) A notification of a decision shall indicate the following, in a manner that is comprehensible to the covered person or enrollee or, if applicable, his/her authorized representative:

- (a) The titles and qualifying credentials of the persons participating in the expedited review process (the reviewers);
- (b) A statement of the reviewers' understanding of the covered person's request for an expedited review;
- (c) The reviewers' decision in clear terms, and the contract basis or medical rationale for the covered person or enrollee to respond to the health insurance organization or insurer's position;
- (d) A reference to the evidence or documentation used as the basis for the decision; and
- (e) If the decision results in a final adverse determination, the notice shall provide:

- (i) The specific reasons for the final adverse determination;

- (ii) Reference to the specific plan provisions on which the determination is based;

- (iii) If the health insurance organization or insurer relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, a copy of such specific rule, guideline, protocol; or other similar criterion relied upon to make the adverse determination shall be provided, upon request and free of charge, to the covered person enrollee;

- (iv) If the final adverse determination is based on a medical necessity, experimental or investigational treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for making the determination;

- (v) If applicable, instructions for requesting:

- (I) a copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination in accordance with clause (e)(iii); or

- (II) A written statement of the scientific or clinical rationale for the adverse determination in accordance with clause (e)(iv);

- (vi) A description of the procedures for obtaining an independent external review pursuant to the subchapter on Health Insurance Organization or Insurer External Review;

- (vii) A statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction;

- (viii) The following statement, stressing the voluntary nature of the procedures: "You and your health plan may have other voluntary alternative dispute resolution options, such as mediation or arbitration. One way to find out what may be available is to contact the Commissioner of Insurance"; and

- (ix) A statement of a covered person or enrollee's right to contact the Commissioner of Insurance or its designee for assistance at any time.

The statement shall include the telephone number and address of the Commissioner of Insurance or its designee.

(2)(A) A health insurance organization or insurer shall provide the notice required under this Section orally, in writing, or electronically.

(B) If notice of the adverse determination is provided orally, the health insurance organization or insurer shall provide written or electronic notice within three (3) days following the oral notification.

(3) None of these provisions shall be construed to limit the power of a health insurance organization or insurer to render an adverse determination ineffective without following the procedure set forth herein.

Section 1961. Rules and Regulations

The insurance commissioner may, in accordance with VI Code Ann., Section 53(c)(1) of Title 22, promulgate reasonable rules and regulations as are necessary or proper to carry out the purposes of this Act.

Section 1962. Severability

If any provisions of this Act, or the application of a provision to any person or circumstances, shall be held invalid. The remainder of the provisions of the Act and the application of the provision to persons or circumstances other than those to which it is held invalid will not be affected.

Section 1963. Effective Date

This Act shall take effect 180 days from the date of enactment.