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HOUSE BILL NO. 619

Offered January 14, 2004

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A BILL to amend and reenact §§ 2.2-2818 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.15, relating to accident and sickness insurance; mandated treatment for infertility.

 Patron—Carrico

 Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2818 and 38.2-4319 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding a section numbered 38.2-3418.15 as follows:

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

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

Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

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

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

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

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

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

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

2. Include coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition.

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

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59 of such Guidelines or Standards or any official amendment thereto.

60 4. Include an appeals process for resolution of written complaints concerning denials or partial
61 denials of claims that shall provide reasonable procedures for resolution of such written complaints and
62 shall be published and disseminated to all covered state employees. The appeals process shall include a
63 separate expedited emergency appeals procedure that shall provide resolution within one business day of
64 receipt of a complaint concerning situations requiring immediate medical care. For appeals involving
65 adverse decisions as defined in § 32.1-137.7, the Department shall contract with one or more impartial
66 health entities to review such decisions. Impartial health entities may include medical peer review
67 organizations and independent utilization review companies. The Department shall adopt regulations to
68 assure that the impartial health entity conducting the reviews has adequate standards, credentials and
69 experience for such review. The impartial health entity shall examine the final denial of claims to
70 determine whether the decision is objective, clinically valid, and compatible with established principles
71 of health care. The decision of the impartial health entity shall (i) be in writing, (ii) contain findings of
72 fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if
73 consistent with law and policy.

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

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

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

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

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

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

108 9. Include coverage for equipment, supplies and outpatient self-management training and education,
109 including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using
110 diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a healthcare professional
111 legally authorized to prescribe such items under law. To qualify for coverage under this subdivision,
112 diabetes outpatient self-management training and education shall be provided by a certified, registered or
113 licensed health care professional.

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

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

12. Include coverage providing a minimum stay in the hospital of not less than ~~forty-eight~~48 hours for a patient following a radical or modified radical mastectomy and ~~twenty-four~~24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

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

14. Permit any individual covered under the plan direct access to the health care services of a participating specialist (i) authorized to provide services under the plan and (ii) selected by the covered individual. The plan shall have a procedure by which an individual who has an ongoing special condition may, after consultation with the primary care physician, receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's primary and specialty care related to the initial specialty care referral. If such an individual's care would most appropriately be coordinated by such a specialist, the plan shall refer the individual to a specialist. For the purposes of this subdivision, "special condition" means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii) requires specialized medical care over a prolonged period of time. Within the treatment period authorized by the referral, such specialist shall be permitted to treat the individual without a further referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services related to the initial referral as the individual's primary care provider would otherwise be permitted to provide or authorize. The plan shall have a procedure by which an individual who has an ongoing special condition that requires ongoing care from a specialist may receive a standing referral to such specialist for the treatment of the special condition. If the primary care provider, in consultation with the plan and the specialist, if any, determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to a specialist. Nothing contained herein shall prohibit the plan from requiring a participating specialist to provide written notification to the covered individual's primary care physician of any visit to such specialist. Such notification may include a description of the health care services rendered at the time of the visit.

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

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

Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the plan to continue rendering health services to any covered employee who has entered the second trimester of pregnancy at the time of the provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue through the provision of postpartum care directly related to the delivery.

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

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

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

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

182 For purposes of this subdivision:

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

187 "FDA" means the Federal Food and Drug Administration.

188 "Multiple project assurance contract" means a contract between an institution and the federal
189 Department of Health and Human Services that defines the relationship of the institution to the federal
190 Department of Health and Human Services and sets out the responsibilities of the institution and the
191 procedures that will be used by the institution to protect human subjects.

192 "NCI" means the National Cancer Institute.

193 "NIH" means the National Institutes of Health.

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

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

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

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

- 205 a. The National Cancer Institute;
206 b. An NCI cooperative group or an NCI center;
207 c. The FDA in the form of an investigational new drug application;
208 d. The federal Department of Veterans Affairs; or
209 e. An institutional review board of an institution in the Commonwealth that has a multiple project
210 assurance contract approved by the Office of Protection from Research Risks of the NCI.

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

213 Coverage under this section shall apply only if:

- 214 (1) There is no clearly superior, noninvestigational treatment alternative;
215 (2) The available clinical or preclinical data provide a reasonable expectation that the treatment will
216 be at least as effective as the noninvestigational alternative; and
217 (3) The patient and the physician or health care provider who provides services to the patient under
218 the plan conclude that the patient's participation in the clinical trial would be appropriate, pursuant to
219 procedures established by the plan.

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

226 18. (Effective until July 1, 2004) Include coverage for biologically based mental illness.

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

233 Coverage for biologically based mental illnesses shall neither be different nor separate from coverage
234 for any other illness, condition or disorder for purposes of determining deductibles, benefit year or
235 lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits,
236 copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and
237 coinsurance factors.

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

243 In no case, however, shall coverage for mental disorders provided pursuant to this section be

diminished or reduced below the coverage in effect for such disorders on January 1, 1999.

19. Offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally. Access to surgery for morbid obesity shall not be restricted based upon dietary or any other criteria not approved by the National Institutes of Health. For purposes of this subdivision, "morbid obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, "BMI" equals weight in kilograms divided by height in meters squared.

20. Include coverage for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations. The coverage for colorectal cancer screening shall not be more restrictive than or separate from coverage provided for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayments and coinsurance factors.

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

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

23. *Include coverage for the treatment of infertility. For the purpose of this subdivision, "infertility" means the inability to conceive after one year of unprotected sexual intercourse. "Treatment for infertility" includes, but is not limited to, the following procedures performed on a covered individual who is less than 50 years old: in vitro fertilization, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, intracytoplasmic sperm injection, zygote intrafallopian transfers and low tubal ovum transfer. Such treatment shall be required only if the covered individual has not undergone four complete oocyte retrievals, except that if a live birth follows a complete oocyte retrieval, then two more oocyte retrievals shall be covered. "Treatment for infertility" does not include the reversal of a vasectomy or a tubal ligation.*

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

D. For the purposes of this section:

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

"Standard reference compendia" means the American Medical Association Drug Evaluations, the

305 American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing
306 Information.

307 "State employee" means state employee as defined in § 51.1-124.3, employee as defined in
308 § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301
309 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and
310 domestic relations, and district courts of the Commonwealth, interns and residents employed by the
311 School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of
312 the Virginia Commonwealth University Health System Authority as provided in § 23-50.16:24.

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

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

320 G. The plan shall include, in each planning district, at least two health coverage options, each
321 sponsored by unrelated entities. In each planning district that does not have an available health coverage
322 alternative, the Department shall voluntarily enter into negotiations at any time with any health coverage
323 provider who seeks to provide coverage under the plan. This section shall not apply to any state agency
324 authorized by the Department to establish and administer its own health insurance coverage plan
325 separate from the plan established by the Department.

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

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

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

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

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

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

350 The Ombudsman shall:

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

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

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

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

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

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

362 7. Upon request, assist covered employees in using the procedures and processes available to them
363 from their health plan, including all appeal procedures. Such assistance may require the review of health
364 care records of a covered employee, which shall be done only with that employee's express written
365 consent. The confidentiality of any such medical records shall be maintained in accordance with the
366 confidentiality and disclosure laws of the Commonwealth.

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

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

M. The plan established in accordance with this section shall not refuse to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by a covered employee.

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

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

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

§ 38.2-3418.15. Coverage for infertility.

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

B. For purposes of this section, "infertility" means the inability to conceive after one year of unprotected sexual intercourse. "Treatment for infertility" includes, but is not limited to, the following procedures performed on a covered individual who is less than 50 years old: in vitro fertilization, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, intracytoplasmic sperm injection, zygote intrafallopian transfers and low tubal ovum transfer. Such treatment shall be required only if the covered individual has not undergone four complete oocyte retrievals, except that if a live birth follows a complete oocyte retrieval, then two more oocyte retrievals shall be covered. "Treatment for infertility" does not include the reversal of a vasectomy or a tubal ligation.

C. The reimbursement for treatment for infertility shall be determined according to the same formula by which charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, deductibles, and coinsurance factors that are no less favorable than for physical illness generally.

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

§ 38.2-4319. (Effective July 1, 2004) Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1017 through 38.2-1023, 38.2-1057, Articles 2 (§ 38.2-1306.2 et seq.), 3.1 (§§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3414.1, 38.2-3418.1 through ~~38.2-3418.12, 38.2-3418.14~~ 38.2-3418.15, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of

§ 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

E. For purposes of applying this section, "insurer" when used in a section cited in subsection A of this section shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.