

2011 SESSION

LEGISLATION NOT PREPARED BY DLS
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HOUSE BILL NO. 2512

Offered January 21, 2011

A *BILL to amend and reenact § 22-2818 of the Code of Virginia, relating to State employee health insurance plan; coverage for autism spectrum disorder.*

Patrons—Hugo, Rust, Greason, Howell, W.J., Sherwood and Ware, R.L.

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 2.2-2818 of the Code of Virginia is amended and reenacted as follows:

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

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

Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

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

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

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

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

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

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

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

3. Include an appeals process for resolution of written complaints concerning denials or partial denials of claims that shall provide reasonable procedures for resolution of such written complaints and shall be published and disseminated to all covered state employees. The appeals process shall include a separate expedited emergency appeals procedure that shall provide resolution within one business day of receipt of a complaint concerning situations requiring immediate medical care. For appeals involving

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59 adverse decisions as defined in § 32.1-137.7, the Department shall contract with one or more impartial
60 health entities to review such decisions. Impartial health entities may include medical peer review
61 organizations and independent utilization review companies. The Department shall adopt regulations to
62 assure that the impartial health entity conducting the reviews has adequate standards, credentials and
63 experience for such review. The impartial health entity shall examine the final denial of claims to
64 determine whether the decision is objective, clinically valid, and compatible with established principles
65 of health care. The decision of the impartial health entity shall (i) be in writing, (ii) contain findings of
66 fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if
67 consistent with law and policy.

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

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

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

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

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

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

102 8. Include coverage for equipment, supplies and outpatient self-management training and education,
103 including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using
104 diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a healthcare professional
105 legally authorized to prescribe such items under law. To qualify for coverage under this subdivision,
106 diabetes outpatient self-management training and education shall be provided by a certified, registered or
107 licensed health care professional.

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

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

115 11. Include coverage providing a minimum stay in the hospital of not less than 48 hours for a patient
116 following a radical or modified radical mastectomy and 24 hours of inpatient care following a total
117 mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing
118 in this subdivision shall be construed as requiring the provision of inpatient coverage where the
119 attending physician in consultation with the patient determines that a shorter period of hospital stay is
120 appropriate.

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

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

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

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

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

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

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

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

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

For purposes of this subdivision:

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

"FDA" means the Federal Food and Drug Administration.

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

186 "NCI" means the National Cancer Institute.

187 "NIH" means the National Institutes of Health.

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

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

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

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

199 a. The National Cancer Institute;

200 b. An NCI cooperative group or an NCI center;

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

202 d. The federal Department of Veterans Affairs; or

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

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

207 Coverage under this subdivision shall apply only if:

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

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

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

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

220 17. Include coverage for biologically based mental illness.

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

227 Coverage for biologically based mental illnesses shall neither be different nor separate from coverage
228 for any other illness, condition or disorder for purposes of determining deductibles, benefit year or
229 lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits,
230 copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and
231 coinsurance factors.

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

237 In no case, however, shall coverage for mental disorders provided pursuant to this section be
238 diminished or reduced below the coverage in effect for such disorders on January 1, 1999.

239 18. Offer and make available coverage for the treatment of morbid obesity through gastric bypass
240 surgery or such other methods as may be recognized by the National Institutes of Health as effective for
241 the long-term reversal of morbid obesity. Such coverage shall have durational limits, dollar limits,
242 deductibles, copayments and coinsurance factors that are no less favorable than for physical illness
243 generally. Access to surgery for morbid obesity shall not be restricted based upon dietary or any other

criteria not approved by the National Institutes of Health. For purposes of this subdivision, "morbid obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, "BMI" equals weight in kilograms divided by height in meters squared.

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

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

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

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

23. *Include coverage for the diagnosis of autism spectrum disorder and the treatment of autism spectrum disorder in individuals from age two through age six, as follows:*

a. As used in this subdivision, unless the context requires a different meaning:

"Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Autism spectrum disorder" means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder - Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Behavioral health treatment" means professional, counseling, and guidance services and treatment programs, including applied behavior analysis when provided or supervised by a board certified behavior analyst, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

"Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder.

"Medically necessary" means based upon evidence and reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, or disability; (ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (iii) assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

"Pharmacy care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

"Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

"Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

"Therapeutic care" means services provided by licensed or certified speech therapists, occupational

therapists, physical therapists, or clinical social workers.

"Treatment for autism spectrum disorder" shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, and (v) therapeutic care.

"Treatment plan" means a plan for the treatment of autism spectrum disorder developed by a licensed physician or a licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

b. Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, the administrator of a plan shall have the right to request a review of that treatment not more than once every 12 months unless the administrator and the individual's licensed physician or licensed psychologist agree that a more frequent review is necessary. The cost of obtaining any review shall be covered under the plan.

c. Coverage under this subdivision shall not be subject to any visit limits, and shall be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining deductibles, lifetime dollar limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

d. Nothing shall preclude the undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of autism spectrum disorder under this subdivision, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by the plan.

e. Any coverage required pursuant to this subdivision shall be in addition to the coverage required by other provisions of law. This subdivision shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan.

f. Coverage under this subdivision will be subject to an annual maximum benefit of \$35,000, unless the plan elects to provide coverage in a greater amount.

g. If an individual who is being treated for autism spectrum disorder becomes seven years of age or older and continues to need treatment, this subdivision shall not preclude coverage for treatment.

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

D. For the purposes of this section:

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

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

"Standard reference compendia" means:

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

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

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

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

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

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

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

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

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

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

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

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

K. L. As of January 1, 2014, to the extent that this section requires benefits that exceed the essential health benefits specified under § 1302(b) of the federal Patient Protection and Affordable Care Act (H.R. 3590), as amended (the ACA), the specific benefits that exceed the specified essential health benefits shall not be required of a qualified health plan when the plan is offered in the Commonwealth by a health carrier through a health benefit exchange established under § 1311 of the ACA. Nothing in this subsection shall nullify application of this section to plans offered outside such an exchange.

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

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

The Ombudsman shall:

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

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

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

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

5. Make available, either separately or through an existing Internet web site utilized by the

428 Department of Human Resource Management, information as set forth in subdivision 4 and such
429 additional information as he deems appropriate.

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

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

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

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

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

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

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

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

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

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

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