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SENATE BILL NO. 252

Offered January 8, 2014

Prefiled January 3, 2014

A BILL to amend and reenact §§ 2.2-2818 and 15.2-1517 of the Code of Virginia, relating to insurance; employees of public institutions of higher education or localities.

Patrons—McEachin and Ebbin

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

- 1. That §§ 2.2-2818 and 15.2-1517 of the Code of Virginia are 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. *For employees of public institutions of higher education, the plan shall provide means whereby coverage of any other class of persons as may mutually be agreed upon by the institution and the employee may be purchased.* Except for part-time employees, the Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee, including a part-time employee, may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

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

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

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

- a. The mammogram shall be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization provider; (ii) performed by a registered technologist; (iii) interpreted by a qualified radiologist; and (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body. A copy of the mammogram report shall be sent or delivered to the health care practitioner who ordered it;
- b. The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and
- c. The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

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

- 3. Include an appeals process for resolution of complaints that shall provide reasonable procedures for the resolution of such complaints and shall be published and disseminated to all covered state

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

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

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

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

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

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

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

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

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

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

120 11. Include coverage providing a minimum stay in the hospital of not less than 48 hours for a patient

121 following a radical or modified radical mastectomy and 24 hours of inpatient care following a total
122 mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing
123 in this subdivision shall be construed as requiring the provision of inpatient coverage where the
124 attending physician in consultation with the patient determines that a shorter period of hospital stay is
125 appropriate.

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

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

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

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

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

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

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

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

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

181 For purposes of this subdivision:

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

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

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

191 "NCI" means the National Cancer Institute.

192 "NIH" means the National Institutes of Health.

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

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

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

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

204 a. The National Cancer Institute;

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

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

207 d. The federal Department of Veterans Affairs; or

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

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

212 Coverage under this subdivision shall apply only if:

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

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

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

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

225 17. Include coverage for biologically based mental illness.

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

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

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

242 18. Offer and make available coverage for the treatment of morbid obesity through gastric bypass
243 surgery or such other methods as may be recognized by the National Institutes of Health as effective for

244 the long-term reversal of morbid obesity. Such coverage shall have durational limits, dollar limits,
 245 deductibles, copayments and coinsurance factors that are no less favorable than for physical illness
 246 generally. Access to surgery for morbid obesity shall not be restricted based upon dietary or any other
 247 criteria not approved by the National Institutes of Health. For purposes of this subdivision, "morbid
 248 obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age,
 249 height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index
 250 (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical
 251 conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of
 252 40 kilograms per meter squared without such comorbidity. As used herein, "BMI" equals weight in
 253 kilograms divided by height in meters squared.

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

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

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

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

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

288 D. For the purposes of this section:

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

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

298 "Standard reference compendia" means:

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

302 "State employee" means state employee as defined in § 51.1-124.3; employee as defined in
 303 § 51.1-201; the Governor, Lieutenant Governor and Attorney General; judge as defined in § 51.1-301
 304 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and

305 domestic relations, and district courts of the Commonwealth; and interns and residents employed by the
306 School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of
307 the Virginia Commonwealth University Health System Authority as provided in § 23-50.16:24.

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

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

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

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

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

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

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

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

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

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

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

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

355 The Ombudsman shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

409 R. The Department of Human Resource Management shall report annually, by November 30 of each
410 year, on cost and utilization information for each of the mandated benefits set forth in subsection B,
411 including any mandated benefit made applicable, pursuant to subdivision B 22, to any plan established
412 pursuant to this section. The report shall be in the same detail and form as required of reports submitted
413 pursuant to § 38.2-3419.1, with such additional information as is required to determine the financial
414 impact, including the costs and benefits, of the particular mandated benefit.

415 **§ 15.2-1517. Insurance for employees and retired employees of localities and other local**
416 **governmental entities; participation by certain volunteers.**

417 A. Any locality may provide group life, *insurance for its officers and employees, and may provide*
418 *group accident, and health insurance programs for its officers and employees and their dependents;*
419 *employees of boards, commissions, agencies, or authorities created by or controlled by such locality and*
420 *the dependents of such employees;* or employees of boards, commissions, agencies, or authorities that are
421 political subdivisions of the Commonwealth and work in close cooperation with such locality *and the*
422 *dependents of such employees.* In addition, any locality that provides such a health insurance program
423 may allow eligible members of approved volunteer fire or rescue companies *and the dependents of such*
424 *members,* as determined by the locality, to participate in such a health insurance program. Such
425 programs may be through a program of self-insurance, purchased insurance, or partial self-insurance and
426 purchased insurance, whichever is determined to be the most cost effective. The total cost of such
427 policies or protection may be paid entirely by the locality or shared with the employee. The governing

428 body of any locality may provide for its retired officers and retired employees to be eligible for such
429 group life, *insurance and may provide for its retired officers and retired employees and their dependents*
430 *to be eligible for such* accident, and health insurance programs. The cost of such insurance for retired
431 officers and retired employees *and their dependents* may be paid in whole or in part by the locality. The
432 governing body of any locality may permit members of approved volunteer fire or rescue companies *and*
433 *the dependents of such members* to participate in its group health insurance programs, subject to the
434 eligibility criteria established by the locality. The cost of a ~~volunteer's~~ participation in such a health
435 insurance program *by such volunteers and their dependents* shall be paid for in full by the participating
436 volunteer.

437 B. In the event a county or city elects to provide one or more of such programs for its officers and
438 employees *and their dependents*, it shall provide such programs to the constitutional officers and their
439 employees *and their dependents* on the same basis as provided to other officers and employees, unless
440 the constitutional officers and employees *and their dependents* are covered under a state program, and
441 the cost of such local program shall be borne entirely by the locality or shared with the employee.

442 C. 1. Except as otherwise provided herein, in the event the governing body of any locality elects to
443 provide group accident and health insurance for its officers and employees *and their dependents*,
444 including constitutional officers and their employees *and their dependents*, such programs shall require
445 that upon retirement, or upon the effective date of this provision for those who have previously retired,
446 any such ~~individual~~ *officer or employee* with (i) at least 15 years of continuous employment with the
447 locality or (ii) less than 15 years of continuous employment who has retired due to line-of-duty injuries
448 may choose to continue his coverage with the insurer at the retiree's expense until such individual attains
449 65 years of age at the insurer's customary premium rate applicable (a) to such policies, (b) to the class
450 of risk to which the person then belongs, and (c) to his age.

451 2. The governing body, when providing this coverage, may further provide that the retiree be rated
452 separately from the active employees covered under the group plan offered by such governing body.

453 3. Any locality that has not offered the opportunity to continue group health coverage provided by
454 the locality as required by subdivision 1 to its retirees who had retired on or before June 30, 1993, and
455 who meet the criteria for such coverage as set forth in subdivision 1, shall do so by July 1, 2000. Any
456 retiree from the service of a locality who had retired on or before June 30, 1993, and who meets the
457 criteria to continue his group health coverage from the locality under subdivision 1 who has not yet
458 elected to continue his group health coverage from the locality shall elect whether to do so by July 1,
459 2000.

460 4. Nothing herein shall prohibit a locality from providing group accident and health coverage or
461 benefits for its retirees in addition to the coverage required under this section.

462 D. Any locality that offers group health plans to its employees and the employees of constitutional
463 officers and its retirees *and their dependents*, as provided by this section or otherwise, may provide in
464 the plan providing such coverage that any retiree who is participating in a group health plan provided by
465 the locality who subsequently terminates his participation in such plan may not thereafter rejoin a group
466 health plan provided by the locality.

467 E. For purposes of this section, "employees" may include teachers or other employees of county, city,
468 and town school boards.

469 F. For purposes of this section, "dependents" means individuals, including qualified adults,
470 recognized as dependents by the locality.