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HOUSE BILL NO. 946

Offered January 11, 2006

Prefiled January 10, 2006

A BILL to amend and reenact § 2.2-2818 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3407.12:1, relating to the assignment of health insurance benefits to physicians rendering emergency services.

Patrons—Morgan, Bell, Cosgrove, Jones, S.C., O'Bannon and Purkey; Senators: Norment and Stolle

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, and that the Code of Virginia is amended by adding a section numbered 38.2-3407.12:1 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 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

59 Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be
60 provided incorporating any changes in such Guidelines or Standards within six months of the publication
61 of such Guidelines or Standards or any official amendment thereto.

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

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

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

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

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

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

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

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

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

11. Include coverage for annual pap smears, including coverage, on and after July 1, 1999, for 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 48 hours for a patient following a radical or modified radical mastectomy and 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 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.

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 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.

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

182 medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles,
183 copayments and coinsurance factors that are no less favorable than for physical illness generally.

184 For purposes of this subdivision:

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

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

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

194 "NCI" means the National Cancer Institute.

195 "NIH" means the National Institutes of Health.

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

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

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

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

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

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

215 Coverage under this subdivision shall apply only if:

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

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

228 18. Include coverage for biologically based mental illness.

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

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

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

covered by such policy or contract.

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, nurse practitioner or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

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

"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

305 the Virginia Commonwealth University Health System Authority as provided in § 23-50.16:24.

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

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

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

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

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

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

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

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

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

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

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

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

349 The Ombudsman shall:

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

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

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

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

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

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

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

366 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 *or to a physician who has rendered medical screening and stabilization services to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd), which services are related to the condition for which the member presented to a hospital emergency facility*, by a covered employee.

For purposes of this subsection, "assignment of benefits" means the transfer of *health care and* 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. Beginning July 1, 2006, any plan established pursuant to this section shall provide for an identification number, which shall be assigned to the covered employee and shall not be the same as the employee's social security number.

O. 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.

P. 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 30 days following the death of such state employee.

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

§ 38.2-3407.12:1. *Refusal to accept assignment of benefits to emergency care physicians.*

A. *Whenever an insured, subscriber, or plan enrollee specifically authorizes or directs, by appropriate instruction on a health insurance claim form, the payment of health care coverage reimbursement benefits directly to any licensed physician who has rendered medical screening and stabilization services to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which the member presented to a hospital emergency facility, the insurer shall make such payment to the designated provider of such services. An insurer's policies, plans, and contracts shall not prohibit, and claim forms shall provide an option for, the payment of health care coverage reimbursement benefits directly to a licensed physician for care provided pursuant to the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd). An insurer may request written attestation of the assignment of benefits prior to making the payment to the provider of such services. Except as may be provided in § 38.2-4312.3, the amount of a payment by an insurer to a provider pursuant to an assignment under this section shall be no more than the amount that the insurer would otherwise have paid without the assignment.*

B. *As used in this section, "insurer" includes (i) insurers proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis; (ii) corporations providing individual or group accident and sickness subscription contracts; and (iii) health maintenance organizations providing a health care plan for health care services.*