

22102914D

**HOUSE BILL NO. 477**

Offered January 12, 2022

Prefiled January 11, 2022

*A BILL to amend and reenact §§ 2.2-2818, 32.1-325, 38.2-3406.1, and 38.2-3418.7 of the Code of Virginia, relating to health insurance; coverage for prostate cancer screening.*

---

 Patron—Austin
 

---



---

 Referred to Committee on Commerce and Energy
 

---

**Be it enacted by the General Assembly of Virginia:**

**1. That §§ 2.2-2818, 32.1-325, 38.2-3406.1, and 38.2-3418.7 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. 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 employees. The appeals process shall be compliant with federal rules and regulations governing

INTRODUCED

HB477

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

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

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

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

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

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

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

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

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

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

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

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 *prostate cancer screening, which includes one PSA prostate-specific antigen 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:

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

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.

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.

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:

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; 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 § 23.1-2415; and

305 employees of the Virginia Alcoholic Beverage Control Authority as provided in § 4.1-101.05.

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

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

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

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

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

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

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

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

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

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

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

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

353 The Ombudsman shall:

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

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

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

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

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

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

365 7. Upon request, assist covered employees in using the procedures and processes available to them  
366 from their health plan, including all appeal procedures. Such assistance may require the review of health

care records of a covered employee, which shall be done only in accordance with the federal Health Insurance Portability and Accountability Act privacy rules. The confidentiality of any such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

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

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

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

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

N. 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.

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

**§ 32.1-325. Board to submit plan for medical assistance services to U.S. Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.**

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time, and submit to the U.S. Secretary of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount not in excess of \$3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value

428 of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender  
429 value of such policies has been excluded from countable resources and (ii) the amount of any other  
430 revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of  
431 meeting the individual's or his spouse's burial expenses;

432 3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically  
433 needy persons whose eligibility for medical assistance is required by federal law to be dependent on the  
434 budget methodology for Aid to Families with Dependent Children, a home means the house and lot used  
435 as the principal residence and all contiguous property. For all other persons, a home shall mean the  
436 house and lot used as the principal residence, as well as all contiguous property, as long as the value of  
437 the land, exclusive of the lot occupied by the house, does not exceed \$5,000. In any case in which the  
438 definition of home as provided here is more restrictive than that provided in the state plan for medical  
439 assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and  
440 lot used as the principal residence and all contiguous property essential to the operation of the home  
441 regardless of value;

442 4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who  
443 are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per  
444 admission;

445 5. A provision for deducting from an institutionalized recipient's income an amount for the  
446 maintenance of the individual's spouse at home;

447 6. A provision for payment of medical assistance on behalf of pregnant women which provides for  
448 payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most  
449 current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American  
450 Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards  
451 for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and  
452 Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the  
453 children which are within the time periods recommended by the attending physicians in accordance with  
454 and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines  
455 or Standards shall include any changes thereto within six months of the publication of such Guidelines  
456 or Standards or any official amendment thereto;

457 7. A provision for the payment for family planning services on behalf of women who were  
458 Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such  
459 family planning services shall begin with delivery and continue for a period of 24 months, if the woman  
460 continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the  
461 purposes of this section, family planning services shall not cover payment for abortion services and no  
462 funds shall be used to perform, assist, encourage or make direct referrals for abortions;

463 8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow  
464 transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast  
465 cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a  
466 performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant.  
467 Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

468 9. A provision identifying entities approved by the Board to receive applications and to determine  
469 eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate  
470 contact information, including the best available address and telephone number, from each applicant for  
471 medical assistance, to the extent required by federal law and regulations, and (ii) provide each applicant  
472 for medical assistance with information about advance directives pursuant to Article 8 (§ 54.1-2981 et  
473 seq.) of Chapter 29 of Title 54.1, including information about the purpose and benefits of advance  
474 directives and how the applicant may make an advance directive;

475 10. A provision for breast reconstructive surgery following the medically necessary removal of a  
476 breast for any medical reason. Breast reductions shall be covered, if prior authorization has been  
477 obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

478 11. A provision for payment of medical assistance for annual pap smears;

479 12. A provision for payment of medical assistance services for prostheses following the medically  
480 necessary complete or partial removal of a breast for any medical reason;

481 13. A provision for payment of medical assistance which provides for payment for 48 hours of  
482 inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of  
483 inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for  
484 treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring  
485 the provision of inpatient coverage where the attending physician in consultation with the patient  
486 determines that a shorter period of hospital stay is appropriate;

487 14. A requirement that certificates of medical necessity for durable medical equipment and any  
488 supporting verifiable documentation shall be signed, dated, and returned by the physician, physician  
489 assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60



days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) 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 *prostate cancer screening, which includes one PSA prostate-specific antigen 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;

16. A provision for payment of medical assistance 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. The term "mammogram" means 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;

17. A provision, when in compliance with federal law and regulation and approved by the Centers for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions, regardless of whether the student receiving care has an individualized education program or whether the health care service is included in a student's individualized education program. Such services shall include those covered under the state plan for medical assistance services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit as specified in § 1905(r) of the federal Social Security Act, and shall include a provision for payment of medical assistance for health care services provided through telemedicine services, as defined in § 38.2-3418.16. No health care provider who provides health care services through telemedicine shall be required to use proprietary technology or applications in order to be reimbursed for providing telemedicine services;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

19. A provision for payment of medical assistance 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;

20. A provision for payment of medical assistance for custom ocular prostheses;

21. A provision for payment for medical assistance 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 provision shall include payment for medical assistance for 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. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer when such women (i) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v) have not attained age 65. This provision shall include an expedited eligibility determination for such

551 women;

552 23. A provision for the coordinated administration, including outreach, enrollment, re-enrollment and  
553 services delivery, of medical assistance services provided to medically indigent children pursuant to this  
554 chapter, which shall be called Family Access to Medical Insurance Security (FAMIS) Plus and the  
555 FAMIS Plan program in § 32.1-351. A single application form shall be used to determine eligibility for  
556 both programs;

557 24. A provision, when authorized by and in compliance with federal law, to establish a public-private  
558 long-term care partnership program between the Commonwealth of Virginia and private insurance  
559 companies that shall be established through the filing of an amendment to the state plan for medical  
560 assistance services by the Department of Medical Assistance Services. The purpose of the program shall  
561 be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for  
562 such services through encouraging the purchase of private long-term care insurance policies that have  
563 been designated as qualified state long-term care insurance partnerships and may be used as the first  
564 source of benefits for the participant's long-term care. Components of the program, including the  
565 treatment of assets for Medicaid eligibility and estate recovery, shall be structured in accordance with  
566 federal law and applicable federal guidelines;

567 25. A provision for the payment of medical assistance for otherwise eligible pregnant women during  
568 the first five years of lawful residence in the United States, pursuant to § 214 of the Children's Health  
569 Insurance Program Reauthorization Act of 2009 (P.L. 111-3);

570 26. A provision for the payment of medical assistance for medically necessary health care services  
571 provided through telemedicine services, as defined in § 38.2-3418.16, regardless of the originating site or  
572 whether the patient is accompanied by a health care provider at the time such services are provided. No  
573 health care provider who provides health care services through telemedicine services shall be required to  
574 use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

575 For the purposes of this subdivision, "originating site" means any location where the patient is  
576 located, including any medical care facility or office of a health care provider, the home of the patient,  
577 the patient's place of employment, or any public or private primary or secondary school or  
578 postsecondary institution of higher education at which the person to whom telemedicine services are  
579 provided is located;

580 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a  
581 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the  
582 Department shall not impose any utilization controls or other forms of medical management limiting the  
583 supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a  
584 12-month supply. Nothing in this subdivision shall be construed to (i) require a provider to prescribe,  
585 dispense, or furnish a 12-month supply of self-administered hormonal contraceptives at one time or (ii)  
586 exclude coverage for hormonal contraceptives as prescribed by a prescriber, acting within his scope of  
587 practice, for reasons other than contraceptive purposes. As used in this subdivision, "hormonal  
588 contraceptive" means a medication taken to prevent pregnancy by means of ingestion of hormones,  
589 including medications containing estrogen or progesterone, that is self-administered, requires a  
590 prescription, and is approved by the U.S. Food and Drug Administration for such purpose; and

591 28. A provision for payment of medical assistance for remote patient monitoring services provided  
592 via telemedicine, as defined in § 38.2-3418.16, for (i) high-risk pregnant persons; (ii) medically  
593 complex infants and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up  
594 to three months following the date of such surgery; and (v) patients with a chronic health condition who  
595 have had two or more hospitalizations or emergency department visits related to such chronic health  
596 condition in the previous 12 months. For the purposes of this subdivision, "remote patient monitoring  
597 services" means the use of digital technologies to collect medical and other forms of health data from  
598 patients in one location and electronically transmit that information securely to health care providers in a  
599 different location for analysis, interpretation, and recommendations, and management of the patient.  
600 "Remote patient monitoring services" includes monitoring of clinical patient data such as weight, blood  
601 pressure, pulse, pulse oximetry, blood glucose, and other patient physiological data, treatment adherence  
602 monitoring, and interactive videoconferencing with or without digital image upload.

603 B. In preparing the plan, the Board shall:

604 1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided  
605 and that the health, safety, security, rights and welfare of patients are ensured.

606 2. Initiate such cost containment or other measures as are set forth in the appropriation act.

607 3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the  
608 provisions of this chapter.

609 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations  
610 pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social  
611 services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact  
612 analysis with local boards of social services prior to submission to the Registrar. The fiscal impact

analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

6. 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 recipient of medical assistance services, 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 recipients such corrective information as may be required to electronically process a prescription claim.

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments that are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider as required by 42 C.F.R. § 1002.212.

4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315, 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal program pursuant to 42 C.F.R. Part 1002.

5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection E of § 32.1-162.13.

For the purposes of this subsection, "provider" may refer to an individual or an entity.

E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. § 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of the date of receipt of the notice.

The Director may consider aggravating and mitigating factors including the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients. In cases in which an agreement or contract is terminated pursuant to subsection D, the Director may determine the period of exclusion and may consider aggravating and mitigating factors to lengthen or shorten the period of exclusion, and may reinstate the provider pursuant to 42 C.F.R. § 1002.215.

F. When the services provided for by such plan are services which a marriage and family therapist, clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed

674 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist,  
675 duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or  
676 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter  
677 shall pay for covered services as provided in the state plan. The Board shall promulgate regulations  
678 which reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical  
679 social workers, licensed professional counselors and licensed clinical nurse specialists at rates based  
680 upon reasonable criteria, including the professional credentials required for licensure.

681 G. The Board shall prepare and submit to the Secretary of the United States Department of Health  
682 and Human Services such amendments to the state plan for medical assistance services as may be  
683 permitted by federal law to establish a program of family assistance whereby children over the age of 18  
684 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of  
685 providing medical assistance under the plan to their parents.

686 H. The Department of Medical Assistance Services shall:

687 1. Include in its provider networks and all of its health maintenance organization contracts a  
688 provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have  
689 special needs and who are Medicaid eligible, including individuals who have been victims of child abuse  
690 and neglect, for medically necessary assessment and treatment services, when such services are delivered  
691 by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a  
692 provider with comparable expertise, as determined by the Director.

693 2. Amend the Medallion II waiver and its implementing regulations to develop and implement an  
694 exception, with procedural requirements, to mandatory enrollment for certain children between birth and  
695 age three certified by the Department of Behavioral Health and Developmental Services as eligible for  
696 services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

697 3. Utilize, to the extent practicable, electronic funds transfer technology for reimbursement to  
698 contractors and enrolled providers for the provision of health care services under Medicaid and the  
699 Family Access to Medical Insurance Security Plan established under § 32.1-351.

700 4. Require any managed care organization with which the Department enters into an agreement for  
701 the provision of medical assistance services to include in any contract between the managed care  
702 organization and a pharmacy benefits manager provisions prohibiting the pharmacy benefits manager or  
703 a representative of the pharmacy benefits manager from conducting spread pricing with regards to the  
704 managed care organization's managed care plans. For the purposes of this subdivision:

705 "Pharmacy benefits management" means the administration or management of prescription drug  
706 benefits provided by a managed care organization for the benefit of covered individuals.

707 "Pharmacy benefits manager" means a person that performs pharmacy benefits management.

708 "Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits  
709 manager charges a managed care plan a contracted price for prescription drugs, and the contracted price  
710 for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly  
711 pays the pharmacist or pharmacy for pharmacist services.

712 I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible  
713 recipients with special needs. The Board shall promulgate regulations regarding these special needs  
714 patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special  
715 needs as defined by the Board.

716 J. Except as provided in subdivision A 1 of § 2.2-4345, the provisions of the Virginia Public  
717 Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by  
718 subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law  
719 and regulation.

720 **§ 38.2-3406.1. Application of requirements that policies offered by small employers include**  
721 **state-mandated health benefits.**

722 A. As used in this section:

723 "Eligible individual" means an individual who is employed by a small employer and has satisfied  
724 applicable waiting period requirements.

725 "Health insurance coverage" means benefits consisting of coverage for costs of medical care, whether  
726 directly, through insurance or reimbursement, or otherwise, and including items and services paid for as  
727 medical care under a group policy of accident and sickness insurance, hospital or medical service policy  
728 or certificate, hospital or medical service plan contract, or health maintenance organization contract,  
729 which coverage is subject to this title or is provided under a plan regulated under the Employee  
730 Retirement Income Security Act of 1974.

731 "Health insurer" means any insurance company that issues accident and sickness insurance policies  
732 providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, a  
733 corporation that provides accident and sickness subscription contracts, or any health maintenance  
734 organization that provides a health care plan that provides, arranges for, pays for, or reimburses any part  
735 of the cost of any health care services, that is licensed to engage in such business in the

Commonwealth, and that is subject to the laws of the Commonwealth that regulate insurance within the meaning of § 514(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144(b)(2)).

"Small employer" has the same meaning ascribed to the term in § 38.2-3431.

"State-mandated health benefit" means coverage required under this title or other laws of the Commonwealth to be provided in a policy of accident and sickness insurance or a contract for a health-related condition that (i) includes coverage for specific health care services or benefits; (ii) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or (iii) includes a specific category of licensed health care practitioners from whom an insured is entitled to receive care. "State-mandated health benefit" includes, without limitation, any coverage, or the offering of coverage, of a benefit or provider pursuant to §§ 38.2-3407.5 through 38.2-3407.6:1, 38.2-3407.9:01, 38.2-3407.9:02, 38.2-3407.11 through 38.2-3407.11:3, 38.2-3407.16, 38.2-3408, 38.2-3411 through 38.2-3414.1, 38.2-3418 through 38.2-3418.14, or § 38.2-4221. For purposes of this article, "state-mandated health benefit" does not include a benefit that is mandated by federal law.

B. Notwithstanding any statute, rule, or regulation to the contrary, and for the purposes of this section, a group accident and sickness insurance policy providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; a group accident and sickness subscription contract providing health insurance coverage for eligible individuals; and a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services that is offered, sold, or issued by a health insurer to a small employer:

1. Shall not be required to include coverage, or the offer of coverage, for any state-mandated health benefit, except for:

- a. Coverage for mammograms pursuant to § 38.2-3418.1;
- b. Coverage for pap smears pursuant to § 38.2-3418.1:2;
- c. Coverage for ~~PSA testing~~ *prostate cancer screening* pursuant to § 38.2-3418.7; and
- d. Coverage for colorectal cancer screening pursuant to § 38.2-3418.7:1.

2. May include any, or none, of the state-mandated health benefits not otherwise noted in subdivision B 1 as the health insurer and the small employer shall agree.

Notwithstanding any provision of this section to the contrary, if any plan authorized by this section includes and offers health care services covered by the plan that may be legally rendered by a health care provider listed in § 38.2-3408, that plan shall allow for the reimbursement of such covered services when rendered by such provider. Unless otherwise provided in this section, this provision shall not require any benefit be provided as a covered service.

C. Any application and any enrollment form used in connection with coverage under this section shall prominently disclose that the policy, contract, or evidence of coverage is not required to provide state-mandated health benefits, shall prominently disclose any and all state-mandated health benefits that the policy, subscription contract, or evidence of coverage does not provide, and shall clearly describe all eligibility requirements.

D. A policy form, subscription contract, or evidence of coverage issued under this section to a small employer shall prominently disclose any and all state-mandated health benefits that the policy, subscription contract, or evidence of coverage does not provide. Such disclosure shall also be included in certificate forms or other evidences of coverage furnished to each participant. Health insurers proposing to issue forms providing coverage under this section shall clearly disclose the intended purposes for such policies, contracts, or evidences of coverage when submitting the forms to the Commission for approval in accordance with § 38.2-316.

E. The Commission shall adopt any regulations necessary to implement this section.

F. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

#### **§ 38.2-3418.7. Coverage for prostate cancer screening.**

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage to (i) persons age ~~fifty~~ 50 and over and (ii) persons age ~~forty~~ 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for ~~one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines prostate cancer screening~~ under any such policy, contract or plan delivered, issued for delivery or renewed in ~~this the~~ Commonwealth on and after ~~July 1, 1998~~ January 1, 2023.

B. For the purpose of this section, "~~PSA testing~~" means the analysis of a blood sample to determine

797 the level of prostate specific antigen "prostate cancer screening" includes one prostate-specific antigen  
798 test in a 12-month period and digital rectal examinations.

799 C. No insurer, corporation, or health maintenance organization shall impose on any person receiving  
800 benefits pursuant to this section any deductible, coinsurance, copayment, or other cost-sharing  
801 requirement, except to the extent that coverage without cost-sharing would disqualify a high-deductible  
802 health benefit plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223.

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