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HOUSE BILL NO. 1936

Offered January 12, 2005

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A BILL to amend and reenact §§ 2.2-2128, 38.2-3418.13, and 38.2-4319 of the Code of Virginia, relating to health insurance; state employees health insurance plan; coverage for treatment of morbid obesity.

Patron—O'Bannon

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2128, 38.2-3418.13, and 38.2-4319 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 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

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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.

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

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

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

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

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

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

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

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

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

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

180 The reimbursement for patient costs incurred during participation in clinical trials for treatment  
181 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 section 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

244 covered by such policy or contract.

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

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

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

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

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

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

290 D. For the purposes of this section:

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

297 "Standard reference compendia" means the American Medical Association Drug Evaluations, the  
298 American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing  
299 Information.

300 "State employee" means state employee as defined in § 51.1-124.3, employee as defined in  
301 § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301  
302 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and  
303 domestic relations, and district courts of the Commonwealth, interns and residents employed by the  
304 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. In each planning district that does not have an available health coverage  
318 alternative, the Department shall voluntarily enter into negotiations at any time with any health coverage  
319 provider who seeks to provide coverage under the plan. This section shall not apply to any state agency  
320 authorized by the Department to establish and administer its own health insurance coverage plan  
321 separate from the plan established by the Department.

322 H. Any self-insured group health insurance plan established by the Department of Personnel that  
323 includes coverage for prescription drugs on an outpatient basis may apply a formulary to the prescription  
324 drug benefits provided by the plan if the formulary is developed, reviewed at least annually, and updated  
325 as necessary in consultation with and with the approval of a pharmacy and therapeutics committee, a  
326 majority of whose members are actively practicing licensed (i) pharmacists, (ii) physicians, and (iii)  
327 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 I. Any plan established in accordance with this section requiring preauthorization prior to rendering  
335 medical treatment shall have personnel available to provide authorization at all times when such  
336 preauthorization is required.

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

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

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

346 The Ombudsman shall:

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

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

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

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

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

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

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

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

366 9. Report annually on his activities to the standing committees of the General Assembly having

367 jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of  
368 each year.

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

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

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

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

389 § 38.2-3418.13. Coverage for the treatment of morbid obesity.

390 A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group  
391 accident and sickness insurance policies providing hospital, medical and surgical, or major medical  
392 coverage on an expense-incurred basis; each corporation providing individual or group accident and  
393 sickness subscription contracts; and each health maintenance organization providing a health care plan  
394 for health care services shall, *with respect to any such policy, contract or plan delivered, issued for*  
395 *delivery, or renewed in this Commonwealth from July 1, 2000, until July 1, 2005, offer and make*  
396 *available, and with respect to any such policy, contract or plan delivered, issued for delivery, or*  
397 *renewed in this Commonwealth on or after July 1, 2005, provide, coverage under any such policy,*  
398 *contract or plan for the treatment of morbid obesity through gastric bypass surgery or such other*  
399 *methods as may be recognized by the National Institutes of Health as effective for the long-term*  
400 *reversal of morbid obesity. The provisions of this section shall apply to any such policy, contract or*  
401 *plan delivered, issued for delivery, or renewed in this Commonwealth on and after July 1, 2000.*

402 B. The reimbursement for the treatment of morbid obesity shall be determined according to the same  
403 formula by which charges are developed for other medical and surgical procedures. Such coverage shall  
404 have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less  
405 favorable than for physical illness generally. Standards and criteria, including those related to diet, used  
406 by insurers to approve or restrict access to surgery for morbid obesity shall be based upon current  
407 clinical guidelines recognized by the National Institutes of Health.

408 C. For purposes of this section, "morbid obesity" means (i) a weight that is at least 100 pounds over  
409 or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life  
410 Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared  
411 with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions,  
412 sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As  
413 used herein, BMI equals weight in kilograms divided by height in meters squared.

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

418 § 38.2-4319. Statutory construction and relationship to other laws.

419 A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this  
420 chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218  
421 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through  
422 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.),  
423 §§ 38.2-1017 through 38.2-1023, 38.2-1057, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1  
424 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1  
425 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836,  
426 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through  
427 38.2-3407.16, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through

**428** ~~38.2-3418.12,~~ 38.2-3418.14, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of  
**429** § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through  
**430** 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter  
**431** 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 of this title shall be  
**432** applicable to any health maintenance organization granted a license under this chapter. This chapter shall  
**433** not apply to an insurer or health services plan licensed and regulated in conformance with the insurance  
**434** laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health  
**435** maintenance organization.

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

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

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

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