H. B. 4076

(By Delegates Perdue, Hatfield, Moore, Moye and Staggers)

[Introduced January 16, 2012; referred to the Committee on Banking and Insurance then the Judiciary.]

Interim Bill

A BILL to amend and reenact §5-16-7 of the Code of West Virginia, 1931, as amended; to amend said code by adding thereto a new section, designated §33-15-4k; to amend said code by adding thereto a new section, designated §33-16-3w; to amend and reenact §33-16E-2 of said code; to amend said code by enacting thereto a new section, designated §33-24-7l; to amend said code by enacting thereto a new section, designated §33-25-8i; and to amend said code by enacting thereto a new section, designated §33-25A-8k, all relating generally to requiring health insurance coverage of maternity and contraceptive services in certain circumstances; providing maternity and contraceptive services for all individuals participating in or receiving insurance coverage under a health insurance policy if those services are covered under the policy; and modifying required benefits for public employees insurance, accident and sickness insurance, group accident and sickness insurance,

hospital medical and dental corporations, health care corporations and health maintenance organizations.

Be it enacted by the Legislature of West Virginia:

That §5-16-7 of the Code of West Virginia, 1931, as amended, be amended and reenacted; that said code be amended by adding thereto a new section, designated §33-15-4k; that said code be amended by adding thereto a new section, designated §33-16-3w; to amend and reenact §33-16E-2 of said code; that said code be amended by adding thereto a new section, designated §33-24-7l; that said code be amended by adding thereto a new section, designated §33-25-8i; and that said code be amended by adding thereto a new section, designated §33-25A-8k, all to read as follows:

CHAPTER 5. GENERAL POWERS AND AUTHORITY OF GOVERNOR, SECRETARY OF STATE AND ATTORNEY GENERAL; BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES, COMMISSIONS, OFFICES, PROGRAMS, ETC.

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

§5-16-7. Authorization to establish group hospital and surgical insurance plan, group major medical insurance plan, group prescription drug plan and group life and accidental death insurance plan; rules for administration of plans; mandated benefits; what plans may provide;

optional plans; separate rating for claims experience purposes.

(a) The agency shall establish a group hospital and surgical insurance plan or plans, a group prescription drug insurance plan or plans, a group major medical insurance plan or plans and a group life and accidental death insurance plan or plans for those employees herein made eligible, and to establish and promulgate rules for the administration of these plans, subject to the limitations contained in this article. Those plans shall include:

(1) Coverages and benefits for X ray and laboratory services in connection with mammograms when medically appropriate and consistent with current guidelines from the United States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists; and a test for the human papilloma virus (HPV) when medically appropriate and consistent with current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists, when performed for cancer screening or diagnostic services on a woman age eighteen or over;

(2) Annual checkups for prostate cancer in men age fifty and over;

(3) Annual screening for kidney disease as determined to be medically necessary by a physician using any combination of blood pressure testing, urine albumin or urine protein testing and serum creatinine testing as recommended by the National Kidney Foundation;

(4) For plans that include maternity benefits, coverage for inpatient care in a duly licensed health care facility for a mother and her newly born infant for the length of time which the attending physician considers medically necessary for the mother or her newly born child: *Provided,* That no plan may deny payment for a mother or her newborn child prior to forty-eight hours following a vaginal delivery, or prior to ninety-six hours following a caesarean section delivery, if the attending physician considers discharge medically inappropriate;

(5) For plans which provide coverages for post-delivery care to a mother and her newly born child in the home, coverage for inpatient care following childbirth as provided in subdivision (4) of this subsection if inpatient care is determined to be medically necessary by the attending physician. Those plans may also include, among other things, medicines, medical equipment, prosthetic appliances and any other inpatient and outpatient services and expenses considered appropriate and desirable by the agency; and

(6) Coverage for treatment of serious mental illness.

(A) The coverage does not include custodial care, residential care or schooling. For purposes of this section, "serious mental illness" means an illness included in the American Psychiatric Association's diagnostic and statistical manual of mental disorders, as periodically revised, under the diagnostic categories or subclassifications of: (I) Schizophrenia and other psychotic disorders; (ii) bipolar disorders; (iii) depressive disorders; (iv) substance-related disorders with the exception of caffeine-related disorders and nicotine-related disorders; (v) anxiety disorders; and (vi) anorexia and bulimia. With regard to any covered individual who has not yet attained the age of nineteen years, "serious mental illness" also includes attention deficit hyperactivity disorder, separation anxiety disorder and conduct disorder.

(B) Notwithstanding any other provision in this section to the contrary, in the event that the agency can demonstrate that its total costs for the treatment of mental illness for any plan exceeded two percent of the total costs for such plan in any experience period, then the agency may apply whatever additional cost-containment measures may be necessary, including, but not limited to, limitations on inpatient and outpatient benefits, to maintain costs below two percent of the total costs for the plan for the next experience period.

(C) The agency shall not discriminate between medical-surgical

benefits and mental health benefits in the administration of its plan. With regard to both medical-surgical and mental health benefits, it may make determinations of medical necessity and appropriateness, and it may use recognized health care quality and cost management tools, including, but not limited to, limitations on inpatient and outpatient benefits, utilization review, implementation of cost-containment measures, preauthorization for certain treatments, setting coverage levels, setting maximum number of visits within certain time periods, using capitated benefit arrangements, using fee-for-service arrangements, using third-party administrators, using provider networks and using patient cost sharing in the form of copayments, deductibles and coinsurance.

(7) Coverage for general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care if the covered person is:

(A) Seven years of age or younger or is developmentally disabled, and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the individual and for whom a superior result can be expected from dental care provided under general anesthesia;

(B) A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with

dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

(8)(A) Any plan issued or renewed after January 1, 2012, shall include coverage for diagnosis and treatment of autism spectrum disorder in individuals ages eighteen months through eighteen years. To be eligible for coverage and benefits under this subdivision, the individual must be diagnosed with autism spectrum disorder at age 8 or younger. Such policy shall provide coverage for treatments that are medically necessary and ordered or prescribed by a licensed physician or licensed psychologist for an individual diagnosed with autism spectrum disorder, in accordance with a treatment plan developed by a certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual, subject to review by the agency every six months. Progress reports are required to be filed with the agency semi-annually. In order for treatment to continue, the agency must receive objective evidence or a clinically supportable statement of expectation that:

(1) The individual’s condition is improving in response to

treatment; and

(2) A maximum improvement is yet to be attained; and

(3) There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

(B) Such coverage shall include, but not be limited to, applied behavioral analysis provided or supervised by a certified behavior analyst: *Provided,* That the annual maximum benefit for treatment required by this subdivision shall be in amount not to exceed $30,000 per individual, for three consecutive years from the date treatment commences. At the conclusion of the third year, required coverage shall be in an amount not to exceed $2000 per month, until the individual reaches eighteen years of age, as long as the treatment is medically necessary and in accordance with a treatment plan developed by a certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual. This section shall not be construed as limiting, replacing or affecting any obligation to provide services to an individual under the Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq., as amended from time to time or other publicly funded programs. Nothing in this subdivision shall be construed as requiring reimbursement for services provided by public school personnel.

(C) On or before January 1 each year, the agency shall file an

annual report with the joint committee on government and finance describing its implementation of the coverage provided pursuant to this subdivision. The report shall include, but shall not be limited to, the number of individuals in the plan utilizing the coverage required by this subdivision, the fiscal and administrative impact of the implementation, and any recommendations the agency may have as to changes in law or policy related to the coverage provided under this subdivision. In addition, the agency shall provide such other information as may be required by the joint committee on government and finance as it may from time to time request.

(D) For purposes of this subdivision, the term:

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

(ii) "Autism spectrum disorder" means any pervasive developmental disorder, including autistic disorder, Asperger's Syndrome, Rett syndrome, childhood disintegrative disorder, or Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(iii) "Certified behavior analyst" means an individual who is certified by the Behavior Analyst Certification Board or certified by a similar nationally recognized organization.

(iv) "Objective evidence" means standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and/or after treatment is recommended to quantify progress and support justifications for continued treatment. Such tools are not required, but their use will enhance the justification for continued treatment.

(E) To the extent that the application of this subdivision for autism spectrum disorder causes an increase of at least one percent of actual total costs of coverage for the plan year the agency may apply additional cost containment measures.

(F) To the extent that the provisions of this subdivision requires benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of insurance plans offered by the public employees insurance agency.

(9) For plans that include maternity benefits, coverage for the same maternity benefits for all individuals participating in or

receiving insurance coverage under insurance plans that are issued or renewed on or after July 1, 2012.

(b) The agency shall make available to each eligible employee, at full cost to the employee, the opportunity to purchase optional group life and accidental death insurance as established under the rules of the agency. In addition, each employee is entitled to have his or her spouse and dependents, as defined by the rules of the agency, included in the optional coverage, at full cost to the employee, for each eligible dependent; and with full authorization to the agency to make the optional coverage available and provide an opportunity of purchase to each employee.

(c) The finance board may cause to be separately rated for claims experience purposes:

(1) All employees of the State of West Virginia;

(2) All teaching and professional employees of state public institutions of higher education and county boards of education;

(3) All nonteaching employees of the Higher Education Policy Commission, West Virginia Council for Community and Technical College Education and county boards of education; or

(4) Any other categorization which would ensure the stability of the overall program.

(d) The agency shall maintain the medical and prescription drug coverage for Medicare-eligible retirees by providing coverage through one of the existing plans or by enrolling the Medicare-

eligible retired employees into a Medicare-specific plan, including, but not limited to, the Medicare/Advantage Prescription Drug Plan. In the event that a Medicare-specific plan would no longer be available or advantageous for the agency and the retirees, the retirees shall remain eligible for coverage through the agency.

CHAPTER 33. INSURANCE

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE

§33-15-4k. Maternity coverage.

Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, any health insurance policy subject to this article that provides health insurance coverage for maternity services shall, on or after July 1, 2012, provide coverage for maternity services for all persons participating in, or receiving coverage under the policy. Coverage required under this section may not be subject to exclusions or limitations which are not applied to other maternity coverage under the policy.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3w. Maternity coverage.

Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, any health insurance policy subject to this article that provides health insurance coverage for maternity services shall, on or after July

1, 2012, provide coverage for maternity services for all persons participating in, or receiving coverage under the policy. Coverage required under this section may not be subject to exclusions or limitations which are not applied to other maternity coverage under the policy.

ARTICLE 16E. CONTRACEPTIVE COVERAGE.

§33-16E-2. Definitions.

For the purposes of this article, these definitions are applicable unless a different meaning clearly appears from the context.

(1) "Contraceptives" means drugs or devices approved by the food and drug administration to prevent maternity.

(2) "Covered person" means the policyholder, subscriber, certificate holder, enrollee or other individual who is participating in, or receiving coverage under a health insurance plan. ~~For the purposes of this article, covered person does not include a dependent child~~.

(3) "Health insurance plan" means benefits consisting of medical care provided directly, through insurance or reimbursement, or indirectly, including items and services paid for as medical care, under any hospital or medical expense incurred policy or certificate; hospital, medical or health service corporation contract; health maintenance organization contract; fraternal benefit society contract; plan provided by a multiple-employer

trust or a multiple-employer welfare arrangement; or plan provided by the West Virginia Public Employees Insurance Agency pursuant to article sixteen, chapter five of this code.

(4) "Outpatient contraceptive services" means consultations, examinations, procedures and medical services, provided on an outpatient basis and related to the use of prescription contraceptive drugs and devices to prevent maternity issued under a health insurance plan that provides benefits for prescription drugs or prescription devices in a prescription drug plan.

(5) "Religious employer" is an entity whose sincerely held religious beliefs or sincerely held moral convictions are central to the employer's operating principles, and the entity is an organization listed under 26 U.S.C. 501 (c)(3), 26 U.S.C. 3121, or listed in the Official Catholic Directory published by P.J. Kennedy and Sons.

ARTICLE 24. HOSPITAL MEDICAL AND DENTAL CORPORATIONS.

§33-24-7l. Maternity coverage.

Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, any health insurance policy subject to this article that provides health insurance coverage for maternity services shall, on or after July 1, 2012, provide coverage for maternity services for all persons participating in, or receiving coverage under the policy. Coverage required under this section may not be subject to exclusions or

limitations which are not applied to other maternity coverage under the policy.

ARTICLE 25. HEALTH CARE CORPORATION.

§33-25-8i. Maternity coverage.

Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, any health insurance policy subject to this article that provides health insurance coverage for maternity services shall, on or after July 1, 2012, provide coverage for maternity services for all persons participating in, or receiving coverage under the policy. Coverage required under this section may not be subject to exclusions or limitations which are not applied to other maternity coverage under the policy.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8k. Maternity coverage.

Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, any health insurance policy subject to this article that provides health insurance coverage for maternity services shall, on or after July 1, 2012, provide coverage for maternity services for all persons participating in, or receiving coverage under the policy. Coverage required under this section may not be subject to exclusions or limitations which are not applied to other maternity coverage under the policy.

NOTE: The purpose of this bill is to require health insurers to cover maternity and contraceptive services for all individuals who are participating in or receiving coverage under a policyholder's health insurance plan, if those services are covered under the policy. Under current law, health insurers are not required to cover maternity or contraceptive services for dependents.

This bill passed out of the Legislative oversight Commission on Health and Human Resource Accountability, recommended for passage.

§33-15-4k, §33-16-3w, §33-24-7l, §33-25-8i, and §33-25A-8k are new; therefore, they have been completely underscored.

Strike-throughs indicate language that would be stricken from the present law, and underscoring indicates new language that would be added.