WEST VIRGINIA LEGISLATURE

2020 REGULAR SESSION

Introduced

Senate Bill 577

FISCAL NOTE

BY SENATORS PREZIOSO, BALDWIN, BEACH, HARDESTY,

IHLENFELD, JEFFRIES, LINDSAY, PLYMALE, ROMANO,

STOLLINGS, PALUMBO, AND WOELFEL

[Introduced January 22, 2020; referred

to the Committee on Banking and Insurance; and then

to the Committee on Finance]

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 §33-16-3ff; and to amend said code by adding thereto a new section, designated §33-24-7u, all relating to insurance coverage for insulin.

Be it enacted by the Legislature of West Virginia:

CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE 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; <u>required payment for insulin capped.</u>

(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 establish and promulgate rules for the administration of these plans subject to the limitations contained in this article. These 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 18 or over;

(2) Annual checkups for prostate cancer in men age 50 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 healthcare 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. No plan may deny payment for a mother or her newborn child prior to 48 hours following a vaginal delivery or prior to 96 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 §5-16-7(a)(4) of this code if inpatient care is determined to be medically necessary by the attending physician. These plans may 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 a covered individual who has not yet attained the age of 19 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, if the agency demonstrates that its total costs for the treatment of mental illness for any plan exceeds 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 in order to maintain costs below two percent of the total costs for the plan for the next experience period. These measures may include, but are not limited to, limitations on inpatient and outpatient benefits.

(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 healthcare 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 healthcare 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 12 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 on or after January 1, 2012, shall include coverage for diagnosis, evaluation, and treatment of autism spectrum disorder in individuals ages 18 months to 18 years. To be eligible for coverage and benefits under this subdivision, the individual must be diagnosed with autism spectrum disorder at age eight or younger. Such plan shall provide coverage for treatments that are medically necessary and ordered or prescribed by a licensed physician or licensed psychologist and in accordance with a treatment plan developed from a comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism spectrum disorder.

(B) The coverage shall include, but not be limited to, applied behavior analysis which shall be provided or supervised by a certified behavior analyst. The annual maximum benefit for applied behavior analysis required by this subdivision shall be in an amount not to exceed $30,000 per individual for three consecutive years from the date treatment commences. At the conclusion of the third year, coverage for applied behavior analysis required by this subdivision shall be in an amount not to exceed $2,000 per month, until the individual reaches 18 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 subdivision does not limit, replace or affect 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 requires reimbursement for services provided by public school personnel.

(C) The certified behavior analyst shall file progress reports with the agency semiannually. In order for treatment to continue, the agency must receive objective evidence or a clinically supportable statement of expectation that:

(i) The individual's condition is improving in response to treatment;

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

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

(D) 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 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 required by the Joint Committee on Government and Finance as it may request.

(E) 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 in order to produce socially significant improvement in human behavior and includes 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 after treatment is recommended to quantify progress and support justifications for continued treatment. The tools are not required but their use will enhance the justification for continued treatment.

(F) 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.

(G) To the extent that the provisions of this subdivision require 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 coverage under plans that are issued or renewed on or after January 1, 2014: Provided, That to the extent that the provisions of this subdivision require 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 a health benefit plan when the plan is offered in this state.

(10) (A) A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that is subject to this section, shall provide coverage, through the age of 20, for amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the

gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state pursuant to either §30-3-1 *et seq.* or §30-14-1 *et seq.* of this code:

(i) Immunoglobulin E and Nonimmunoglobulin E-medicated allergies to multiple food proteins;

(ii) Severe food protein-induced enterocolitis syndrome;

(iii) Eosinophilic disorders as evidenced by the results of a biopsy; and

(iv) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract (short bowel).

(B) The coverage required by §5-16-7(a)(10)(A) of this code shall include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary, regardless of methodology of delivery.

(C) For purposes of this subdivision, “medically necessary foods” or “medical foods” shall mean prescription amino acid-based elemental formulas obtained through a pharmacy: Provided, That these foods are specifically designated and manufactured for the treatment of severe allergic conditions or short bowel.

(D) The provisions of this subdivision shall not apply to persons with an intolerance for lactose or soy.

(b) The agency shall, with full authorization, 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.

(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. If a Medicare-specific plan is no longer available or advantageous for the agency and the retirees, the retirees remain eligible for coverage through the agency.

(e) A policy, plan or contract that is issued or renewed on or after January 1, 2020, shall cap the total amount that a covered employee or dependent is required to pay for a covered prescription insulin drug at an amount not to exceed $100 per 30-day supply of insulin, regardless of the amount or type of insulin needed.

CHAPTER33. INSURANCE.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3ff. Cap on insured persons payment for insulin.

An insurer who, on or after January 1, 2020, delivers or issues a policy of group accident and sickness insurance in this state under the provisions of this article shall cap the total amount that an insured patient is required to pay for a covered prescription insulin drug at an amount not to exceed $100 per 30-day supply of insulin, regardless of the amount or type of insulin needed.

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS AND HEALTH SERVICE CORPORATIONS.

§33-24-7u. Cap on insured persons payment for insulin.

A policy, plan or contract issued on or after January 1, 2020, and that is subject to the provisions of this article shall cap the total amount that a person participating or receiving coverage therefrom is required to pay for a covered prescription insulin drug at an amount not to exceed $100 per 30-day supply of insulin, regardless of the amount or type of insulin needed.

NOTE: The purpose of this bill is to limit the amount that an insured person is required to pay for his or her insulin prescription to $100 per 30-day supply.

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