H. B. 2383

(By Delegates Perdue and Moore)

[Introduced February 13, 2013; referred to the Committee on Banking and Insurance then the Judiciary.]

FISCAL NOTE

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 adding thereto a new section, designated §33-24-7l; to amend said code by adding thereto a new section, designated §33-25-8i; and to amend said code by adding thereto a new section, designated §33-25A-8k, all relating to requiring all insurers, health care organizations, hospital medical corporations and health maintenance organizations that offer maternity coverage in their health care plans to provide that maternity coverage to all persons receiving coverage under the plans; and requiring health insurance plans that include a prescription drug plan to cover contraceptive services for all individuals

1 participating in or receiving coverage under that plan.
2 *Be it enacted by the Legislature of West Virginia:*
3 That §5-16-7 of the Code of West Virginia, 1931, as amended,
4 be amended and reenacted; that said code be amended by adding
5 thereto a new section, designated §33-15-4k; that said code be
6 amended by adding thereto a new section, designated §33-16-3w; to
7 amend and reenact §33-16E-2 of said code; that said code be amended
8 by adding thereto a new section, designated §33-24-7l; that said
9 code be amended by adding thereto a new section, designated
10 §33-25-8i; and that said code be amended by adding thereto a new
11 section, designated §33-25A-8k, all to read as follows:
12 **CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE GOVERNOR,**
13 **SECRETARY OF STATE AND ATTORNEY GENERAL; BOARD**
14 **OF PUBLIC WORKS; MISCELLANEOUS AGENCIES, COMMISSIONS,**
15 **OFFICES, PROGRAMS, ETC.**
16 **ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.**
17 **§5-16-7. Authorization to establish group hospital and surgical**
18 **insurance plan, group major medical insurance plan,**
19 **group prescription drug plan and group life and**
20 **accidental death insurance plan; rules for**
21 **administration of plans; mandated benefits; what**
22 **plans may provide; optional plans; separate rating**
23 **for claims experience purposes.**

1 (a) The agency shall establish a group hospital and surgical
2 insurance plan or plans, a group prescription drug insurance plan
3 or plans, a group major medical insurance plan or plans and a group
4 life and accidental death insurance plan or plans for those
5 employees herein made eligible, and to establish and promulgate
6 rules for the administration of these plans, subject to the
7 limitations contained in this article. Those plans shall include:
8 (1) Coverages and benefits for x ray and laboratory services
9 in connection with mammograms when medically appropriate and
10 consistent with current guidelines from the United States
11 Preventive Services Task Force; pap smears, either conventional or
12 liquid-based cytology, whichever is medically appropriate and
13 consistent with the current guidelines from either the United
14 States Preventive Services Task Force or The American College of
15 Obstetricians and Gynecologists; and a test for the human papilloma
16 virus (HPV) when medically appropriate and consistent with current
17 guidelines from either the United States Preventive Services Task
18 Force or The American College of Obstetricians and Gynecologists,
19 when performed for cancer screening or diagnostic services on a
20 woman age eighteen or over;
21 (2) Annual checkups for prostate cancer in men age fifty and
22 over;
23 (3) Annual screening for kidney disease as determined to be
24 medically necessary by a physician using any combination of blood

1 pressure testing, urine albumin or urine protein testing and serum
2 creatinine testing as recommended by the National Kidney
3 Foundation;
4 (4) For plans that include maternity benefits, coverage for
5 inpatient care in a duly licensed health care facility for a mother
6 and her newly born infant for the length of time which the
7 attending physician considers medically necessary for the mother or
8 her newly born child: *Provided,* That no plan may deny payment for
9 a mother or her newborn child prior to forty-eight hours following
10 a vaginal delivery, or prior to ninety-six hours following a
11 caesarean section delivery, if the attending physician considers
12 discharge medically inappropriate;
13 (5) For plans which provide coverages for post-delivery care
14 to a mother and her newly born child in the home, coverage for
15 inpatient care following childbirth as provided in subdivision (4)
16 of this subsection if inpatient care is determined to be medically
17 necessary by the attending physician. Those plans may also include,
18 among other things, medicines, medical equipment, prosthetic
19 appliances and any other inpatient and outpatient services and
20 expenses considered appropriate and desirable by the agency; and
21 (6) Coverage for treatment of serious mental illness.
22 (A) The coverage does not include custodial care, residential
23 care or schooling. For purposes of this section, "serious mental
24 illness" means an illness included in the American Psychiatric

1 Association's diagnostic and statistical manual of mental
2 disorders, as periodically revised, under the diagnostic categories
3 or subclassifications of: (i) Schizophrenia and other psychotic
4 disorders; (ii) bipolar disorders; (iii) depressive disorders; (iv)
5 substance-related disorders with the exception of caffeine-related
6 disorders and nicotine-related disorders; (v) anxiety disorders;
7 and (vi) anorexia and bulimia. With regard to any covered
8 individual who has not yet attained the age of nineteen years,
9 "serious mental illness" also includes attention deficit
10 hyperactivity disorder, separation anxiety disorder and conduct
11 disorder.

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

21 (C) The agency shall not discriminate between medical-surgical
22 benefits and mental health benefits in the administration of its
23 plan. With regard to both medical-surgical and mental health
24 benefits, it may make determinations of medical necessity and

1 appropriateness, and it may use recognized health care quality and
2 cost management tools, including, but not limited to, limitations
3 on inpatient and outpatient benefits, utilization review,
4 implementation of cost-containment measures, preauthorization for
5 certain treatments, setting coverage levels, setting maximum number
6 of visits within certain time periods, using capitated benefit
7 arrangements, using fee-for-service arrangements, using third-party
8 administrators, using provider networks and using patient cost
9 sharing in the form of copayments, deductibles and coinsurance.
10 (7) Coverage for general anesthesia for dental procedures and
11 associated outpatient hospital or ambulatory facility charges
12 provided by appropriately licensed health care individuals in
13 conjunction with dental care if the covered person is:
14 (A) Seven years of age or younger or is developmentally
15 disabled, and is an individual for whom a successful result cannot
16 be expected from dental care provided under local anesthesia
17 because of a physical, intellectual or other medically compromising
18 condition of the individual and for whom a superior result can be
19 expected from dental care provided under general anesthesia;
20 (B) A child who is twelve years of age or younger with
21 documented phobias, or with documented mental illness, and with
22 dental needs of such magnitude that treatment should not be delayed
23 or deferred and for whom lack of treatment can be expected to
24 result in infection, loss of teeth or other increased oral or

1 dental morbidity and for whom a successful result cannot be
2 expected from dental care provided under local anesthesia because
3 of such condition and for whom a superior result can be expected
4 from dental care provided under general anesthesia.
5 (8) (A) Any plan issued or renewed on or after January 1,
6 2012, shall include coverage for diagnosis, evaluation and
7 treatment of autism spectrum disorder in individuals ages eighteen
8 months to eighteen years. To be eligible for coverage and benefits
9 under this subdivision, the individual must be diagnosed with
10 autism spectrum disorder at age eight or younger. Such policy
11 shall provide coverage for treatments that are medically necessary
12 and ordered or prescribed by a licensed physician or licensed
13 psychologist and in accordance with a treatment plan developed from
14 a comprehensive evaluation by a certified behavior analyst for an
15 individual diagnosed with autism spectrum disorder.
16 (B) The coverage shall include, but not be limited to, applied
17 behavior analysis. Applied behavior analysis shall be provided or
18 supervised by a certified behavior analyst. The annual maximum
19 benefit for applied behavior analysis required by this subdivision
20 shall be in an amount not to exceed $30,000 per individual, for
21 three consecutive years from the date treatment commences. At the
22 conclusion of the third year, coverage for applied behavior
23 analysis required by this subdivision shall be in an amount not to
24 exceed $2,000 per month, until the individual reaches eighteen

1 years of age, as long as the treatment is medically necessary and
2 in accordance with a treatment plan developed by a certified
3 behavior analyst pursuant to a comprehensive evaluation or
4 reevaluation of the individual. This subdivision shall not be
5 construed as limiting, replacing or affecting any obligation to
6 provide services to an individual under the Individuals with
7 Disabilities Education Act, 20 U.S.C. 1400 et seq., as amended from
8 time to time or other publicly funded programs. Nothing in this
9 subdivision shall be construed as requiring reimbursement for
10 services provided by public school personnel.
11 (C) The certified behavior analyst shall file progress reports
12 with the agency semiannually. In order for treatment to continue,
13 the agency must receive objective evidence or a clinically
14 supportable statement of expectation that:
15 (i) The individual's condition is improving in response to
16 treatment; and
17 (ii) A maximum improvement is yet to be attained; and
18 (iii) There is an expectation that the anticipated improvement
19 is attainable in a reasonable and generally predictable period of
20 time.
21 (D) On or before January 1 each year, the agency shall file an
22 annual report with the Joint Committee on Government and Finance
23 describing its implementation of the coverage provided pursuant to
24 this subdivision. The report shall include, but shall not be

1 limited to, the number of individuals in the plan utilizing the
2 coverage required by this subdivision, the fiscal and
3 administrative impact of the implementation, and any
4 recommendations the agency may have as to changes in law or policy
5 related to the coverage provided under this subdivision. In
6 addition, the agency shall provide such other information as may be
7 required by the Joint Committee on Government and Finance as it may
8 from time to time request.
9 (E) For purposes of this subdivision, the term:
10 (i) "Applied Behavior Analysis" means the design,
11 implementation, and evaluation of environmental modifications using
12 behavioral stimuli and consequences, to produce socially
13 significant improvement in human behavior, including the use of
14 direct observation, measurement, and functional analysis of the
15 relationship between environment and behavior.
16 (ii) "Autism spectrum disorder" means any pervasive
17 developmental disorder, including autistic disorder, Asperger's
18 Syndrome, Rett Syndrome, childhood disintegrative disorder, or
19 Pervasive Development Disorder as defined in the most recent
20 edition of the Diagnostic and Statistical Manual of Mental
21 Disorders of the American Psychiatric Association.
22 (iii) "Certified behavior analyst" means an individual who is
23 certified by the Behavior Analyst Certification Board or certified
24 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.

<u>(9) For plans that include maternity benefits, coverage for those maternity benefits shall include all individuals participating in or receiving insurance coverage under insurance plans that are issued or renewed on or after July 1, 2013.</u>

(b) The agency shall make available to each eligible employee, at full cost to the employee, the opportunity to purchase optional

1 group life and accidental death insurance as established under the
2 rules of the agency. In addition, each employee is entitled to have
3 his or her spouse and dependents, as defined by the rules of the
4 agency, included in the optional coverage, at full cost to the
5 employee, for each eligible dependent; and with full authorization
6 to the agency to make the optional coverage available and provide
7 an opportunity of purchase to each employee.
8 (c) The finance board may cause to be separately rated for
9 claims experience purposes:
10 (1) All employees of the State of West Virginia;
11 (2) All teaching and professional employees of state public
12 institutions of higher education and county boards of education;
13 (3) All nonteaching employees of the Higher Education Policy
14 Commission, West Virginia Council for Community and Technical
15 College Education and county boards of education; or
16 (4) Any other categorization which would ensure the stability
17 of the overall program.
18 (d) The agency shall maintain the medical and prescription
19 drug coverage for Medicare-eligible retirees by providing coverage
20 through one of the existing plans or by enrolling the
21 Medicare-eligible retired employees into a Medicare-specific plan,
22 including, but not limited to, the Medicare/Advantage Prescription
23 Drug Plan. In the event that a Medicare specific plan would no
24 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 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, 2013, 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 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, 2013, 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.

1 **ARTICLE 16E. CONTRACEPTIVE COVERAGE.**

2 **§33-16E-2. Definitions.**

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

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

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

13 (3) "Health insurance plan" means benefits consisting of
14 medical care provided directly, through insurance or reimbursement,
15 or indirectly, including items and services paid for as medical
16 care, under any hospital or medical expense incurred policy or
17 certificate; hospital, medical or health service corporation
18 contract; health maintenance organization contract; fraternal
19 benefit society contract; plan provided by a multiple-employer
20 trust or a multiple-employer welfare arrangement; or plan provided
21 by the West Virginia Public Employees Insurance Agency pursuant to
22 article sixteen, chapter five of this code.

23 (4) "Outpatient contraceptive services" means consultations,
24 examinations, procedures and medical services, provided on an

1 outpatient basis and related to the use of prescription
2 contraceptive drugs and devices to prevent maternity issued under
3 a health insurance plan that provides benefits for prescription
4 drugs or prescription devices in a prescription drug plan.
5 (5) “Religious employer” is an entity whose sincerely held
6 religious beliefs or sincerely held moral convictions are central
7 to the employer’s operating principles, and the entity is an
8 organization listed under 26 U.S.C. §501(c)(3), 26 U.S.C. §3121, or
9 listed in the Official Catholic Directory published by P.J. Kennedy
10 and Sons.

11 **ARTICLE 24. HOSPITAL MEDICAL AND DENTAL CORPORATIONS.**

12 <u>**§33-24-7l. Maternity coverage.**</u>

13 <u>Notwithstanding any policy, provision, contract, plan or</u>
14 <u>agreement applicable to this article, any health insurance policy</u>
15 <u>subject to this article that provides health insurance coverage for</u>
16 <u>maternity services shall, on or after July 1, 2013, provide</u>
17 <u>coverage for maternity services for all persons participating in,</u>
18 <u>or receiving coverage under the policy. Coverage required under</u>
19 <u>this section may not be subject to exclusions or limitations which</u>
20 <u>are not applied to other maternity coverage under the policy.</u>

21 **ARTICLE 25. HEALTH CARE CORPORATION.**

22 <u>**§33-25-8i. Maternity coverage.**</u>

23 <u>Notwithstanding any policy, provision, contract, plan or</u>

1 agreement applicable to this article, any health insurance policy
2 subject to this article that provides health insurance coverage for
3 maternity services shall, on or after July 1, 2013, provide
4 coverage for maternity services for all persons participating in,
5 or receiving coverage under the policy. Coverage required under
6 this section may not be subject to exclusions or limitations which
7 are not applied to other maternity coverage under the policy.

8 **ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.**

9 **§33-25A-8k. Maternity coverage.**

10 Notwithstanding any policy, provision, contract, plan or
11 agreement applicable to this article, any health insurance policy
12 subject to this article that provides health insurance coverage for
13 maternity services shall, on or after July 1, 2013, provide
14 coverage for maternity services for all persons participating in,
15 or receiving coverage under the policy. Coverage required under
16 this section may not be subject to exclusions or limitations which
17 are not applied to other maternity coverage under the policy.

NOTE: The purpose of this bill is to require health insurers that offer maternity service coverage to cover all individuals who are participating in or receiving coverage under a policyholder's health insurance plan. The bill changes the current law that excludes contraceptive services for dependents of policyholders if the policy includes a prescription drug plan to cover contraceptive services.

§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.