

WEST VIRGINIA LEGISLATURE

2017 REGULAR SESSION

Introduced

House Bill 2051

**FISCAL
NOTE**

BY DELEGATE RODIGHIERO

[Introduced February 8, 2017; Referred
to the Committee on Banking and Insurance then
Finance.]

1 A BILL to amend and reenact §5-16-7 of the Code of West Virginia, 1931, as amended, relating
 2 to the West Virginia Public Employees Insurance Act; and authorizing insurance to married
 3 workers without children at reduced rates.

Be it enacted by the Legislature of West Virginia:

1 That §5-16-7 of the Code of West Virginia, 1931, as amended, be amended and reenacted
 2 to read as follows:

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.

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

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

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

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

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

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

31 (6) For plans which provide coverage for each eligible employee who is married but without
32 covered children, at a lesser premium cost than benefits for eligible employees who are married
33 with children; and

34 ~~(6)~~ (7) Coverage for treatment of serious mental illness.

35 (A) The coverage does not include custodial care, residential care or schooling. For
36 purposes of this section, "serious mental illness" means an illness included in the American
37 Psychiatric Association's diagnostic and statistical manual of mental disorders, as periodically
38 revised, under the diagnostic categories or subclassifications of: (i) Schizophrenia and other
39 psychotic disorders; (ii) bipolar disorders; (iii) depressive disorders; (iv) substance-related
40 disorders with the exception of caffeine-related disorders and nicotine-related disorders; (v)

41 anxiety disorders; and (vi) anorexia and bulimia. With regard to any covered individual who has
42 not yet attained the age of nineteen years, "serious mental illness" also includes attention deficit
43 hyperactivity disorder, separation anxiety disorder and conduct disorder.

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

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

59 ~~(7)~~ (8) Coverage for general anesthesia for dental procedures and associated outpatient
60 hospital or ambulatory facility charges provided by appropriately licensed health care individuals
61 in conjunction with dental care if the covered person is:

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

66 (B) A child who is twelve years of age or younger with documented phobias, or with
67 documented mental illness, and with dental needs of such magnitude that treatment should not
68 be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss
69 of teeth or other increased oral or dental morbidity and for whom a successful result cannot be
70 expected from dental care provided under local anesthesia because of such condition and for
71 whom a superior result can be expected from dental care provided under general anesthesia.

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

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

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

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

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

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

85 (d) The agency shall maintain the medical and prescription drug coverage for Medicare
86 eligible retirees by providing coverage through one of the existing plans or by enrolling the
87 Medicare eligible retired employees into a Medicare specific plan, including, but not limited to, the
88 Medicare/Advantage Prescription Drug Plan. In the event that a Medicare specific plan would no
89 longer be available or advantageous for the agency and the retirees, the retirees shall remain
90 eligible for coverage through the agency.

NOTE: The purpose of this bill is to authorize insurance to married workers without children at reduced rates under the West Virginia Public Employees Insurance Act.

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