

# WEST VIRGINIA LEGISLATURE

## 2019 REGULAR SESSION

Introduced

### House Bill 2577

FISCAL  
NOTE

BY DELEGATE RODIGHIERO

[Introduced January 22, 2019; 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:*

**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 establish and promulgate rules for the administration of these plans subject to the  
 5 limitations contained in this article. These plans shall include:

6 (1) Coverages and benefits for x-ray 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 18 or over;

15 (2) Annual checkups for prostate cancer in men age 50 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 healthcare 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. No plan may  
22 deny payment for a mother or her newborn child prior to 48 hours following a vaginal delivery or  
23 prior to 96 hours following a caesarean section delivery if the attending physician considers  
24 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 §5-16-7(a)(4)  
27 of this code if inpatient care is determined to be medically necessary by the attending physician.  
28 These plans may include, among other things, medicines, medical equipment, prosthetic  
29 appliances, and any other inpatient and outpatient services and expenses considered appropriate  
30 and desirable by the agency;

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 a covered individual who has not  
42 yet attained the age of 19 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, if the agency  
45 demonstrates that its total costs for the treatment of mental illness for any plan exceeds two  
46 percent of the total costs for such plan in any experience period, then the agency may apply  
47 whatever additional cost-containment measures may be necessary in order to maintain costs  
48 below two percent of the total costs for the plan for the next experience period. These measures  
49 may include, but are not limited to, limitations on inpatient and outpatient benefits.

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 healthcare 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 healthcare 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  
65 and for whom a superior result can be expected from dental care provided under general  
66 anesthesia.

67 (B) A child who is 12 years of age or younger with documented phobias or with  
68 documented mental illness and with dental needs of such magnitude that treatment should not be

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

73 ~~(8)~~ (9) (A) Any plan issued or renewed on or after January 1, 2012, shall include coverage  
74 for diagnosis, evaluation, and treatment of autism spectrum disorder in individuals ages 18  
75 months to 18 years. To be eligible for coverage and benefits under this subdivision, the individual  
76 must be diagnosed with autism spectrum disorder at age eight or younger. Such plan shall provide  
77 coverage for treatments that are medically necessary and ordered or prescribed by a licensed  
78 physician or licensed psychologist and in accordance with a treatment plan developed from a  
79 comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism  
80 spectrum disorder.

81 (B) The coverage shall include, but not be limited to, applied behavior analysis which shall  
82 be provided or supervised by a certified behavior analyst. The annual maximum benefit for applied  
83 behavior analysis required by this subdivision shall be in an amount not to exceed \$30,000 per  
84 individual for three consecutive years from the date treatment commences. At the conclusion of  
85 the third year, coverage for applied behavior analysis required by this subdivision shall be in an  
86 amount not to exceed \$2,000 per month, until the individual reaches 18 years of age, as long as  
87 the treatment is medically necessary and in accordance with a treatment plan developed by a  
88 certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the  
89 individual. This subdivision does not limit, replace or affect any obligation to provide services to  
90 an individual under the Individuals with Disabilities Education Act, 20 U. S. C. §1400 et seq., as  
91 amended from time to time or other publicly funded programs. Nothing in this subdivision requires  
92 reimbursement for services provided by public school personnel.

93 (C) The certified behavior analyst shall file progress reports with the agency semiannually.  
94 In order for treatment to continue, the agency must receive objective evidence or a clinically

95 supportable statement of expectation that:

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

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

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

100 (D) On or before January 1 each year, the agency shall file an annual report with the Joint  
101 Committee on Government and Finance describing its implementation of the coverage provided  
102 pursuant to this subdivision. The report shall include, but not be limited to, the number of  
103 individuals in the plan utilizing the coverage required by this subdivision, the fiscal and  
104 administrative impact of the implementation and any recommendations the agency may have as  
105 to changes in law or policy related to the coverage provided under this subdivision. In addition,  
106 the agency shall provide such other information as required by the Joint Committee on  
107 Government and Finance as it may request.

108 (E) For purposes of this subdivision, the term:

109 (i) "Applied behavior analysis" means the design, implementation and evaluation of  
110 environmental modifications using behavioral stimuli and consequences in order to produce  
111 socially significant improvement in human behavior and includes the use of direct observation,  
112 measurement, and functional analysis of the relationship between environment and behavior.

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

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

119 (iv) "Objective evidence" means standardized patient assessment instruments, outcome  
120 measurements tools, or measurable assessments of functional outcome. Use of objective

121 measures at the beginning of treatment, during, and after treatment is recommended to quantify  
122 progress and support justifications for continued treatment. The tools are not required but their  
123 use will enhance the justification for continued treatment.

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

127 (G) To the extent that the provisions of this subdivision require benefits that exceed the  
128 essential health benefits specified under section 1302(b) of the Patient Protection and Affordable  
129 Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified  
130 essential health benefits shall not be required of insurance plans offered by the Public Employees  
131 Insurance Agency.

132 ~~(9)~~(10) For plans that include maternity benefits, coverage for the same maternity benefits  
133 for all individuals participating in or receiving coverage under plans that are issued or renewed on  
134 or after January 1, 2014: *Provided*, That to the extent that the provisions of this subdivision require  
135 benefits that exceed the essential health benefits specified under section 1302(b) of the Patient  
136 Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that  
137 exceed the specified essential health benefits shall not be required of a health benefit plan when  
138 the plan is offered in this state.

139 ~~(40)~~ (11) (A) A policy, plan, or contract that is issued or renewed on or after January 1,  
140 2019, and that is subject to this section, shall provide coverage, through the age of 20, for amino  
141 acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption  
142 of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of  
143 the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the  
144 disorder by a physician licensed to practice in this state pursuant to either §30-3-1 et seq. or §30-  
145 14-1 et seq. of this code:

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

147 proteins;

148 (ii) Severe food protein-induced enterocolitis syndrome;

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

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

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

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

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

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

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

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

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

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

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



173 (d) The agency shall maintain the medical and prescription drug coverage for Medicare-  
174 eligible retirees by providing coverage through one of the existing plans or by enrolling the  
175 Medicare-eligible retired employees into a Medicare-specific plan, including, but not limited to, the  
176 Medicare/Advantage Prescription Drug Plan. If a Medicare-specific plan is no longer available or  
177 advantageous for the agency and the retirees, the retirees remain eligible for coverage through  
178 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.