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OFFICE WEST VIRGINIA
SECRETARY OF STATE

WEST VIRGINIA LEGISLATURE

SECOND REGULAR SESSION, 2002



ENROLLED

COMMITTEE SUBSTITUTE
FOR
House Bill No. 4039

(By Mr. Speaker, Mr. Kiss, and Delegate Trump)
[By Request of the Executive]



Passed March 8, 2002

In Effect Ninety Days from Passage

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FOR

H. B. 4039

(BY MR. SPEAKER, MR. KISS, AND DELEGATE TRUMP)

[BY REQUEST OF THE EXECUTIVE]

[Passed March 8, 2002; in effect ninety days from passage.]

AN ACT to amend and reenact section seven, article sixteen, chapter five of the code of West Virginia, one thousand nine hundred thirty-one, as amended; and to amend and reenact section three-a, article sixteen, chapter thirty-three of said code; and to amend and reenact section two, article twenty-five-a of said chapter, all relating to mental health benefit coverage.

Be it enacted by the Legislature of West Virginia:

That section seven, article sixteen, chapter five of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted; that section three-a, article sixteen, chapter thirty-three of said code be amended and reenacted; and that section two, article twenty-five-a of said chapter be amended and reenacted, all to read as follows:

**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.

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

9 (1) Coverages and benefits for X ray and laboratory
10 services in connection with mammograms and pap smears when
11 performed for cancer screening or diagnostic services;

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

14 (3) For plans that include maternity benefits, coverage for
15 inpatient care in a duly licensed health care facility for a mother
16 and her newly born infant for the length of time which the
17 attending physician considers medically necessary for the
18 mother or her newly born child: *Provided*, That no plan may

19 deny payment for a mother or her new born child prior to
20 forty-eight hours following a vaginal delivery, or prior to
21 ninety-six hours following a caesarean section delivery, if the
22 attending physician considers discharge medically inappropri-
23 ate;

24 (4) For plans which provide coverages for post-delivery
25 care to a mother and her newly born child in the home, cover-
26 age for inpatient care following childbirth as provided in
27 subdivision (3) of this subsection if inpatient care is determined
28 to be medically necessary by the attending physician. Those
29 plans may also include, among other things, medicines, medical
30 equipment, prosthetic appliances, and any other inpatient and
31 outpatient services and expenses considered appropriate and
32 desirable by the agency; and

33 (5) Coverage for treatment of serious mental illness.

34 (A) The coverage does not include custodial care, residen-
35 tial care or schooling. For purposes of this section, "serious
36 mental illness" means an illness included in the American
37 psychiatric association's diagnostic and statistical manual of
38 mental disorders, as periodically revised, under the diagnostic
39 categories or subclassifications of: (i) Schizophrenia and other
40 psychotic disorders; (ii) bipolar disorders; (iii) depressive
41 disorders; (iv) substance-related disorders with the exception of
42 caffeine-related disorders and nicotine-related disorders; (v)
43 anxiety disorders; and (vi) anorexia and bulimia. With regard
44 to any covered individual who has not yet attained the age of
45 nineteen years, "serious mental illness" also includes attention
46 deficit hyperactivity disorder, separation anxiety disorder, and
47 conduct disorder.

48 (B) Notwithstanding any other provision in this section to
49 the contrary, in the event that the agency can demonstrate
50 actuarially that its total anticipated costs for the treatment of

51 mental illness for any plan will exceed or have exceeded two
52 percent of the total costs for such plan in any experience period,
53 then the agency may apply whatever cost containment measures
54 may be necessary, including, but not limited to, limitations on
55 inpatient and outpatient benefits, to maintain costs below two
56 percent of the total costs for the plan.

57 (C) The agency shall not discriminate between medical-
58 surgical benefits and mental health benefits in the administra-
59 tion of its plan. With regard to both medical-surgical and
60 mental health benefits, it may make determinations of medical
61 necessity and appropriateness, and it may use recognized health
62 care quality and cost management tools, including, but not
63 limited to, limitations on inpatient and outpatient benefits,
64 utilization review, implementation of cost containment mea-
65 sures, preauthorization for certain treatments, setting coverage
66 levels, setting maximum number of visits within certain time
67 periods, using capitated benefit arrangements, using fee-for-
68 service arrangements, using third-party administrators, using
69 provider networks and using patient cost sharing in the form of
70 copayments, deductibles and coinsurance.

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

81 (c) The finance board may cause to be separately rated for
82 claims experience purposes: (1) All employees of the state of
83 West Virginia; (2) all teaching and professional employees of

84 state public institutions of higher education and county boards
85 of education; (3) all nonteaching employees of the university of
86 West Virginia board of trustees or the board of directors of the
87 state college system and county boards of education; or (4) any
88 other categorization which would ensure the stability of the
89 overall program.

CHAPTER 33. INSURANCE.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3a. Same — Mental health.

1 (a)(1) Notwithstanding the requirements of subsection (b)
2 of this section, any health benefits plan described in this article
3 that is delivered, issued or renewed in this state shall provide
4 benefits to all individual subscribers and members and to all
5 group members for expenses arising from treatment of serious
6 mental illness. The expenses do not include custodial care,
7 residential care or schooling. For purposes of this section,
8 “serious mental illness” means an illness included in the
9 American psychiatric association’s diagnostic and statistical
10 manual of mental disorders, as periodically revised, under the
11 diagnostic categories or subclassifications of: (i) Schizophrenia
12 and other psychotic disorders; (ii) bipolar disorders; (iii)
13 depressive disorders; (iv) substance-related disorders with the
14 exception of caffeine-related disorders and nicotine-related
15 disorders; (v) anxiety disorders; and (vi) anorexia and bulimia.

16 (2) Notwithstanding any other provision in this section to
17 the contrary, in the event that an insurer can demonstrate
18 actuarially to the insurance commissioner that its total anti-
19 cipated costs for treatment for mental illness, for any plan will
20 exceed or have exceeded two percent of the total costs for such
21 plan in any experience period, then the insurer may apply
22 whatever cost containment measures may be necessary,
23 including, but not limited to, limitations on inpatient and

24 outpatient benefits, to maintain costs below two percent of the
25 total costs for the plan: *Provided, however*, That for any group
26 with twenty-five members or less, the insurer may apply such
27 additional cost containment measures as may be necessary if
28 the total anticipated actual costs for the treatment of mental
29 illness will exceed one percent of the total costs for the group.

30 (3) The insurer shall not discriminate between medical-
31 surgical benefits and mental health benefits in the administra-
32 tion of its plan. With regard to both medical-surgical and
33 mental health benefits, it may make determinations of medical
34 necessity and appropriateness, and it may use recognized health
35 care quality and cost management tools, including, but not
36 limited to, utilization review, use of provider networks,
37 implementation of cost containment measures, preauthorization
38 for certain treatments, setting coverage levels including the
39 number of visits in a given time period, using capitated benefit
40 arrangements, using fee-for-service arrangements, using third-
41 party administrators, and using patient cost sharing in the form
42 of copayments, deductibles and coinsurance.

43 (4) The provisions of this subsection shall apply with
44 respect to group health plans for plan years beginning on or
45 after the first day of January, two thousand three. The provi-
46 sions of this section shall cease to be effective on and after the
47 thirty-first day of March, two thousand seven, unless further
48 extended by the Legislature.

49 (5) The commissioner on or before the thirty-first day of
50 December, two thousand five, and annually thereafter, shall
51 report to the Legislature's joint committee on government and
52 finance and the committees on insurance of the respective
53 houses of the Legislature regarding the fiscal impact of this
54 subsection on the expenses of insurers affected thereby, and
55 which insurers expenses of providing mental health benefits

56 have exceeded the percentage limits established by this subsection.

57 (b) With respect to mental health benefits furnished to an
58 enrollee of a health benefit plan offered in connection with a
59 group health plan, for a plan year beginning on or after the first
60 day of January, one thousand nine hundred ninety-eight the
61 following requirements shall apply to aggregate lifetime limits
62 and annual limits.

63 (1) Aggregate lifetime limits:

64 (A) If the health benefit plan does not include an aggregate
65 lifetime limit on substantially all medical and surgical benefits,
66 as defined under the terms of the plan but not including mental
67 health benefits, the plan may not impose any aggregate lifetime
68 limit on mental health benefits;

69 (B) If the health benefit plan limits the total amount that
70 may be paid with respect to an individual or other coverage unit
71 for substantially all medical and surgical benefits (in this
72 paragraph, "applicable lifetime limit"), the plan shall either
73 apply the applicable lifetime limit to medical and surgical
74 benefits to which it would otherwise apply and to mental health
75 benefits, as defined under the terms of the plan, and not
76 distinguish in the application of the limit between medical and
77 surgical benefits and mental health benefits, or not include any
78 aggregate lifetime limit on mental health benefits that is less
79 than the applicable lifetime limit;

80 (C) If a health benefit plan not previously described in this
81 subdivision includes no or different aggregate lifetime limits on
82 different categories of medical and surgical benefits, the
83 commissioner shall propose rules for legislative approval in
84 accordance with the provisions of article three, chapter
85 twenty-nine-a of this code under which paragraph (B) of this
86 subdivision shall apply, substituting an average aggregate
87 lifetime limit for the applicable lifetime limit.

88 (2) Annual limits:

89 (A) If a health benefit plan does not include an annual limit
90 on substantially all medical and surgical benefits, as defined
91 under the terms of the plan but not including mental health
92 benefits, the plan may not impose any annual limit on mental
93 health benefits, as defined under the terms of the plan;

94 (B) If the health benefit plan limits the total amount that
95 may be paid in a twelve-month period with respect to an
96 individual or other coverage unit for substantially all medical
97 and surgical benefits (in this paragraph, “applicable annual
98 limit”), the plan shall either apply the applicable annual limit to
99 medical and surgical benefits to which it would otherwise apply
100 and to mental health benefits, as defined under the terms of the
101 plan, and not distinguish in the application of the limit between
102 medical and surgical benefits and mental health benefits, or not
103 include any annual limit on mental health benefits that is less
104 than the applicable annual limit;

105 (C) If a health benefit plan not previously described in this
106 subdivision includes no or different annual limits on different
107 categories of medical and surgical benefits, the commissioner
108 shall propose rules for legislative approval in accordance with
109 the provisions of article three, chapter twenty-nine-a of this
110 code under which paragraph (B) of this subdivision shall apply,
111 substituting an average annual limit for the applicable annual
112 limit.

113 (3) If a group health plan or a health insurer offers a
114 participant or beneficiary two or more benefit package options,
115 this subsection shall apply separately with respect to coverage
116 under each option.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-2. Definitions.

1 (1) "Basic health care services" means physician, hospital,
2 out-of-area, podiatric, chiropractic, laboratory, X ray, emer-
3 gency, treatment for serious mental illness as provided in
4 section three-a, article sixteen of this chapter, and cost-effective
5 preventive services including immunizations, well-child care,
6 periodic health evaluations for adults, voluntary family plan-
7 ning services, infertility services, and children's eye and ear
8 examinations conducted to determine the need for vision and
9 hearing corrections, which services need not necessarily include
10 all procedures or services offered by a service provider.

11 (2) "Capitation" means the fixed amount paid by a health
12 maintenance organization to a health care provider under
13 contract with the health maintenance organization in exchange
14 for the rendering of health care services.

15 (3) "Commissioner" means the commissioner of insurance.

16 (4) "Consumer" means any person who is not a provider of
17 care or an employee, officer, director or stockholder of any
18 provider of care.

19 (5) "Copayment" means a specific dollar amount, or
20 percentage, except as otherwise provided for by statute, that the
21 subscriber must pay upon receipt of covered health care
22 services and which is set at an amount or percentage consistent
23 with allowing subscriber access to health care services.

24 (6) "Employee" means a person in some official employ-
25 ment or position working for a salary or wage continuously for
26 no less than one calendar quarter and who is in such a relation
27 to another person that the latter may control the work of the
28 former and direct the manner in which the work shall be done.

29 (7) "Employer" means any individual, corporation, partner-
30 ship, other private association, or state or local government that

31 employs the equivalent of at least two full-time employees
32 during any four consecutive calendar quarters.

33 (8) "Enrollee", "subscriber" or "member" means an
34 individual who has been voluntarily enrolled in a health
35 maintenance organization, including individuals on whose
36 behalf a contractual arrangement has been entered into with a
37 health maintenance organization to receive health care services.

38 (9) "Evidence of coverage" means any certificate, agree-
39 ment or contract issued to an enrollee setting out the coverage
40 and other rights to which the enrollee is entitled.

41 (10) "Health care services" means any services or goods
42 included in the furnishing to any individual of medical, mental
43 or dental care, or hospitalization or incident to the furnishing of
44 the care or hospitalization, osteopathic services, chiropractic
45 services, podiatric services, home health, health education or
46 rehabilitation, as well as the furnishing to any person of any and
47 all other services or goods for the purpose of preventing,
48 alleviating, curing or healing human illness or injury.

49 (11) "Health maintenance organization" or "HMO" means
50 a public or private organization which provides, or otherwise
51 makes available to enrollees, health care services, including at
52 a minimum basic health care services and which:

53 (a) Receives premiums for the provision of basic health
54 care services to enrollees on a prepaid per capita or prepaid
55 aggregate fixed sum basis, excluding copayments;

56 (b) Provides physicians' services primarily: (i) Directly
57 through physicians who are either employees or partners of the
58 organization; or (ii) through arrangements with individual
59 physicians or one or more groups of physicians organized on a
60 group practice or individual practice arrangement; or (iii)

61 through some combination of paragraphs (i) and (ii) of this
62 subdivision;

63 (c) Assures the availability, accessibility and quality,
64 including effective utilization, of the health care services which
65 it provides or makes available through clearly identifiable focal
66 points of legal and administrative responsibility; and

67 (d) Offers services through an organized delivery system in
68 which a primary care physician or primary care provider is
69 designated for each subscriber upon enrollment. The primary
70 care physician or primary care provider is responsible for
71 coordinating the health care of the subscriber and is responsible
72 for referring the subscriber to other providers when necessary:
73 *Provided*, That when dental care is provided by the health
74 maintenance organization the dentist selected by the subscriber
75 from the list provided by the health maintenance organization
76 shall coordinate the covered dental care of the subscriber, as
77 approved by the primary care physician or the health mainte-
78 nance organization.

79 (12) "Impaired" means a financial situation in which, based
80 upon the financial information which would be required by this
81 chapter for the preparation of the health maintenance organiza-
82 tion's annual statement, the assets of the health maintenance
83 organization are less than the sum of all of its liabilities and
84 required reserves including any minimum capital and surplus
85 required of the health maintenance organization by this chapter
86 so as to maintain its authority to transact the kinds of business
87 or insurance it is authorized to transact.

88 (13) "Individual practice arrangement" means any agree-
89 ment or arrangement to provide medical services on behalf of
90 a health maintenance organization among or between physi-
91 cians or between a health maintenance organization and
92 individual physicians or groups of physicians, where the

93 physicians are not employees or partners of the health mainte-
94 nance organization and are not members of or affiliated with a
95 medical group.

96 (14) “Insolvent” or “insolvency” means a financial situation
97 in which, based upon the financial information that would be
98 required by this chapter for the preparation of the health
99 maintenance organization’s annual statement, the assets of the
100 health maintenance organization are less than the sum of all of
101 its liabilities and required reserves.

102 (15) “Medical group” or “group practice” means a profes-
103 sional corporation, partnership, association or other organiza-
104 tion composed solely of health professionals licensed to
105 practice medicine or osteopathy and of other licensed health
106 professionals, including podiatrists, dentists and optometrists,
107 as are necessary for the provision of health services for which
108 the group is responsible: (a) A majority of the members of
109 which are licensed to practice medicine or osteopathy; (b) who
110 as their principal professional activity engage in the coordinated
111 practice of their profession; (c) who pool their income for
112 practice as members of the group and distribute it among
113 themselves according to a prearranged salary, drawing account
114 or other plan; and (d) who share medical and other records and
115 substantial portions of major equipment and professional,
116 technical and administrative staff.

117 (16) “Premium” means a prepaid per capita or prepaid
118 aggregate fixed sum unrelated to the actual or potential utiliza-
119 tion of services of any particular person which is charged by the
120 health maintenance organization for health services provided to
121 an enrollee.

122 (17) “Primary care physician” means the general practitio-
123 ner, family practitioner, obstetrician/gynecologist, pediatrician
124 or specialist in general internal medicine who is chosen or

125 designated for each subscriber who will be responsible for
126 coordinating the health care of the subscriber, including
127 necessary referrals to other providers.

128 (18) "Primary care provider" means a person who may be
129 chosen or designated in lieu of a primary care physician for
130 each subscriber, who will be responsible for coordinating the
131 health care of the subscriber, including necessary referrals to
132 other providers, and includes:

133 (a) An advanced nurse practitioner practicing in compliance
134 with article seven, chapter thirty of this code and other applica-
135 ble state and federal laws, who develops a mutually agreed
136 upon association in writing with a primary care physician on the
137 panel of and credentialed by the health maintenance organiza-
138 tion; and

139 (b) A certified nurse-midwife, but only if chosen or
140 designated in lieu of a subscriber's primary care physician or
141 primary care provider during the subscriber's pregnancy and for
142 a period extending through the end of the month in which the
143 sixty-day period following termination of pregnancy ends.

144 (c) Nothing in this subsection may be construed to expand
145 the scope of practice for advanced nurse practitioners as
146 governed by article seven, chapter thirty of this code or any
147 legislative rule, or for certified nurse-midwives, as defined in
148 article fifteen, chapter thirty of this code.

149 (19) "Provider" means any physician, hospital or other
150 person or organization which is licensed or otherwise autho-
151 rized in this state to furnish health care services.

152 (20) "Uncovered expenses" means the cost of health care
153 services that are covered by a health maintenance organization,
154 for which a subscriber would also be liable in the event of the
155 insolvency of the organization.

156 (21) "Service area" means the county or counties approved
157 by the commissioner within which the health maintenance
158 organization may provide or arrange for health care services to
159 be available to its subscribers.

160 (22) "Statutory surplus" means the minimum amount of
161 unencumbered surplus which a corporation must maintain
162 pursuant to the requirements of this article.

163 (23) "Surplus" means the amount by which a corporation's
164 assets exceeds its liabilities and required reserves based upon
165 the financial information which would be required by this
166 chapter for the preparation of the corporation's annual state-
167 ment except that assets pledged to secure debts not reflected on
168 the books of the health maintenance organization shall not be
169 included in surplus.

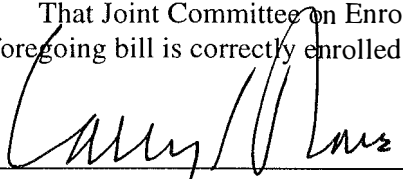
170 (24) "Surplus notes" means debt which has been subordi-
171 nated to all claims of subscribers and general creditors of the
172 organization.

173 (25) "Qualified independent actuary" means an actuary who
174 is a member of the American academy of actuaries or the
175 society of actuaries and has experience in establishing rates for
176 health maintenance organizations and who has no financial or
177 employment interest in the health maintenance organization.

178 (26) "Quality assurance" means an ongoing program
179 designed to objectively and systematically monitor and evaluate
180 the quality and appropriateness of the enrollee's care, pursue
181 opportunities to improve the enrollee's care and to resolve
182 identified problems at the prevailing professional standard of
183 care.

184 (27) "Utilization management" means a system for the
185 evaluation of the necessity, appropriateness and efficiency of
186 the use of health care services, procedure and facilities.

That Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.



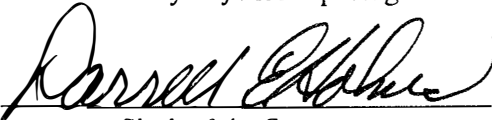
Chairman Senate Committee



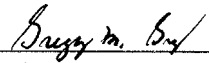
Chairman House Committee

Originating in the House.

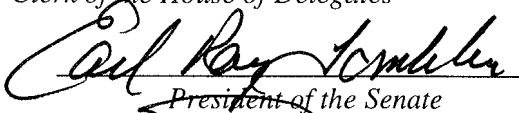
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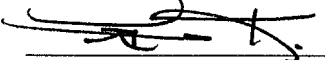
Clerk of the Senate



Clerk of the House of Delegates



President of the Senate



Speaker of the House of Delegates

The within is approved this the 2nd
day of April, 2012.



Governor

PRESENTED TO THE
GOVERNOR

DATE

3/22/02

TIME

2:48