# 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.

(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 to establish and promulgate rules for the administration of these plans, subject to the limitations contained in this article. Those plans shall include:

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

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

(3) For plans that include maternity benefits, coverage for inpatient care in a duly licensed health care 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: *Provided*, That no plan may

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

(4) 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 subdivision (3) of this subsection if inpatient care is determined to be medically necessary by the attending physician. Those plans may also 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

(5) 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 any covered individual who has not yet attained the age of nineteen 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, in the event that the agency can demonstrate actuarially that its total anticipated costs for the treatment of

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

(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 health care quality and cost management tools, including, but not limited to, limitations on impatient 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.

(b) The agency shall 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; and with full authorization to the agency to make the optional coverage available and provide an opportunity of purchase to each employee.

(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 university of West Virginia board of trustees or the board of directors of the state college system and county boards of education; or (4) any other categorization which would ensure the stability of the overall program.

## CHAPTER 33. INSURANCE.

### ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

### §33-16-3a. Same — Mental health.

(a)(1) Notwithstanding the requirements of subsection (b) of this section, any health benefits plan described in this article that is delivered, issued or renewed in this state shall provide benefits to all individual subscribers and members and to all group members for expenses arising from treatment of serious mental illness. The expenses do 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.

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

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

(3) The insurer 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 health care quality and cost management tools, including, but not limited to, utilization review, use of provider networks, implementation of cost containment measures, preauthorization for certain treatments, setting coverage levels including the number of visits in a given time period, using capitated benefit arrangements, using fee-for-service arrangements, using third-party administrators, and using patient cost sharing in the form of copayments, deductibles and coinsurance.

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

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

have exceeded the percentage limits established by this subsection.

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

(1) Aggregate lifetime limits:

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

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

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

(2) Annual limits:

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

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

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

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

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

**§33-25A-2. Definitions.**

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

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

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

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

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

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

(7) "Employer" means any individual, corporation, partnership, other private association, or state or local government that

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

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

(9) "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee setting out the coverage and other rights to which the enrollee is entitled.

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

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

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

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

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

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

(d) Offers services through an organized delivery system in which a primary care physician or primary care provider is designated for each subscriber upon enrollment. The primary care physician or primary care provider is responsible for coordinating the health care of the subscriber and is responsible for referring the subscriber to other providers when necessary: *Provided,* That when dental care is provided by the health maintenance organization the dentist selected by the subscriber from the list provided by the health maintenance organization shall coordinate the covered dental care of the subscriber, as approved by the primary care physician or the health maintenance organization.

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

(13) "Individual practice arrangement" means any agreement or arrangement to provide medical services on behalf of a health maintenance organization among or between physicians or between a health maintenance organization and individual physicians or groups of physicians, where the

physicians are not employees or partners of the health maintenance organization and are not members of or affiliated with a medical group.

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

(15) "Medical group" or "group practice" means a professional corporation, partnership, association or other organization composed solely of health professionals licensed to practice medicine or osteopathy and of other licensed health professionals, including podiatrists, dentists and optometrists, as are necessary for the provision of health services for which the group is responsible: (a) A majority of the members of which are licensed to practice medicine or osteopathy; (b) who as their principal professional activity engage in the coordinated practice of their profession; (c) who pool their income for practice as members of the group and distribute it among themselves according to a prearranged salary, drawing account or other plan; and (d) who share medical and other records and substantial portions of major equipment and professional, technical and administrative staff.

(16) "Premium" means a prepaid per capita or prepaid aggregate fixed sum unrelated to the actual or potential utilization of services of any particular person which is charged by the health maintenance organization for health services provided to an enrollee.

(17) "Primary care physician" means the general practitioner, family practitioner, obstetrician/gynecologist, pediatrician or specialist in general internal medicine who is chosen or

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

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

(a) An advanced nurse practitioner practicing in compliance with article seven, chapter thirty of this code and other applicable state and federal laws, who develops a mutually agreed upon association in writing with a primary care physician on the panel of and credentialed by the health maintenance organization; and

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

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

(19)"Provider" means any physician, hospital or other person or organization which is licensed or otherwise authorized in this state to furnish health care services.

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

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

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

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

(24) "Surplus notes" means debt which has been subordinated to all claims of subscribers and general creditors of the organization.

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

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

(27) "Utilization management" means a system for the evaluation of the necessity, appropriateness and efficiency of 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.

In effect ninety days from passage.

*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, 2002.

*Governor*

PRESENTED TO THE
GOVERNOR
DATE 3/22/02
TIME 2:45