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OFFICE WEST VIRGINIA
SECRETARY OF STATE

SB 185

WEST VIRGINIA LEGISLATURE

SEVENTY-EIGHTH LEGISLATURE

REGULAR SESSION, 2007

ENROLLED

Committee Substitute

Senate Bill No. 18

(SENATORS PREZIOSO, MINARD, STOLLINGS, HUNTER, KESSLER, SPROUSE AND MCCABE, *original sponsors*)

[Passed March 5, 2007; in effect ninety days from passage.]

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(SENATORS PREZIOSO, MINARD, STOLLINGS, HUNTER, KESSLER, SPROUSE AND MCCABE, *original sponsors*)

[Passed March 5, 2007; in effect ninety days from passage.]

AN ACT to amend and reenact §5-16-7 and §5-16-9 of the Code of West Virginia, 1931, as amended; to amend said code by adding thereto a new section, designated §9-5-20; to amend said code by adding thereto a new section, designated §33-15-4i; to amend said code by adding thereto a new section, designated §33-16-3s; to amend said code by adding thereto a new section, designated §33-24-7i; to amend said code by adding thereto a new section, designated §33-25-8g; and to amend said code by adding thereto a new section, designated §33-25A-8h, all relating to modifying required insurance benefits; modifying required benefits for public employees insurance, accident and sickness insurance, group accident

and sickness insurance, hospital service corporations, medical service corporations, dental service corporations, health service corporations, health care corporations and health maintenance organizations; requiring insurance policies and medical benefit plans to include certain coverages when medically appropriate and consistent with relevant national guidelines; requiring coverage from Medicaid for testing for chronic kidney disease; public education of providers on management of chronic kidney disease; defining diagnostic criteria for chronic kidney disease; ensuring the Public Employees Insurance Agency will continue and maintain medical and prescription drug coverage for Medicare-eligible retired employees; and providing that if a Medicare/Advantage Prescription Drug Plan should fail, the Public Employees Insurance Agency will take all Medicare-eligible retired employees back into the existing Public Employees Insurance Agency plan or provide another plan of equal or better coverage.

Be it enacted by the Legislature of West Virginia:

That §5-16-7 and §5-16-9 of the Code of West Virginia, 1931, as amended, be amended and reenacted; that said code be amended by adding thereto a new section, designated §9-5-20; that said code be amended by adding thereto a new section, designated 33-15-4i; that said code be amended by adding thereto a new section, designated §33-16-3s; that said code be amended by adding thereto a new section, designated §33-24-7i; that said code be amended by adding thereto a new section, designated §33-25-8g; and that said code be amended by adding thereto a new section, designated §33-25A-8h, 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
2 surgical insurance plan or plans, a group prescription
3 drug insurance plan or plans, a group major medical
4 insurance plan or plans and a group life and accidental
5 death insurance plan or plans for those employees
6 herein made eligible and to establish and promulgate
7 rules for the administration of these plans, subject to
8 the limitations contained in this article. Those plans
9 shall include:

10 (1) Coverages and benefits for X-ray and laboratory
11 services in connection with mammograms when
12 medically appropriate and consistent with current
13 guidelines from the United States Preventive Services
14 Task Force; pap smears, either conventional or liquid-
15 based cytology, whichever is medically appropriate and
16 consistent with the current guidelines from either the
17 United States Preventive Services Task Force or The
18 American College of Obstetricians and Gynecologists;
19 and a test for the human papilloma virus (HPV) when
20 medically appropriate and consistent with current
21 guidelines from either the United States Preventive
22 Services Task Force or The American College of
23 Obstetricians and Gynecologists, when performed for
24 cancer screening or diagnostic services on a woman age
25 eighteen or over;

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

28 (3) Annual screening for kidney disease as determined
29 to be medically necessary by a physician using any
30 combination of blood pressure testing, urine albumin or
31 urine protein testing and serum creatinine testing as
32 recommended by the National Kidney Foundation.

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

43 (5) For plans which provide coverages for
44 post-delivery care to a mother and her newly born child
45 in the home, coverage for inpatient care following
46 childbirth as provided in subdivision (3) of this
47 subsection if inpatient care is determined to be
48 medically necessary by the attending physician. Those
49 plans may also include, among other things, medicines,
50 medical equipment, prosthetic appliances and any other
51 inpatient and outpatient services and expenses
52 considered appropriate and desirable by the agency;
53 and

54 (6) Coverage for treatment of serious mental illness.

55 (A) The coverage does not include custodial care,
56 residential care or schooling. For purposes of this
57 section, "serious mental illness" means an illness
58 included in the American Psychiatric Association's
59 diagnostic and statistical manual of mental disorders, as
60 periodically revised, under the diagnostic categories or
61 subclassifications of: (i) Schizophrenia and other
62 psychotic disorders; (ii) bipolar disorders; (iii)
63 depressive disorders; (iv) substance-related disorders
64 with the exception of caffeine-related disorders and
65 nicotine-related disorders; (v) anxiety disorders; and (vi)
66 anorexia and bulimia. With regard to any covered
67 individual who has not yet attained the age of nineteen
68 years, "serious mental illness" also includes attention
69 deficit hyperactivity disorder, separation anxiety
70 disorder and conduct disorder.

71 (B) Notwithstanding any other provision in this

72 section to the contrary, in the event that the agency can
73 demonstrate actuarially that its total anticipated costs
74 for the treatment of mental illness for any plan will
75 exceed or have exceeded two percent of the total costs
76 for such plan in any experience period, then the agency
77 may apply whatever cost containment measures may be
78 necessary, including, but not limited to, limitations on
79 inpatient and outpatient benefits, to maintain costs
80 below two percent of the total costs for the plan.

81 (C) The agency shall not discriminate between
82 medical-surgical benefits and mental health benefits in
83 the administration of its plan. With regard to both
84 medical-surgical and mental health benefits, it may
85 make determinations of medical necessity and
86 appropriateness and it may use recognized health care
87 quality and cost management tools, including, but not
88 limited to, limitations on inpatient and outpatient
89 benefits, utilization review, implementation of cost-
90 containment measures, preauthorization for certain
91 treatments, setting coverage levels, setting maximum
92 number of visits within certain time periods, using
93 capitated benefit arrangements, using fee-for-service
94 arrangements, using third-party administrators, using
95 provider networks and using patient cost sharing in the
96 form of copayments, deductibles and coinsurance.

97 (b) The agency shall make available to each eligible
98 employee, at full cost to the employee, the opportunity
99 to purchase optional group life and accidental death
100 insurance as established under the rules of the agency.
101 In addition, each employee is entitled to have his or her
102 spouse and dependents, as defined by the rules of the
103 agency, included in the optional coverage, at full cost to
104 the employee, for each eligible dependent; and with full
105 authorization to the agency to make the optional
106 coverage available and provide an opportunity of
107 purchase to each employee.

108 (c) The finance board may cause to be separately rated
109 for claims experience purposes: (1) All employees of the
110 State of West Virginia; (2) all teaching and professional
111 employees of state public institutions of higher

112 education and county boards of education; (3) all
113 nonteaching employees of the university of West
114 Virginia board of trustees or the board of directors of
115 the State College System and county boards of
116 education; or (4) any other categorization which would
117 ensure the stability of the overall program.

118 (d) The agency shall maintain the medical and
119 prescription drug coverage for Medicare-eligible
120 retirees by providing that coverage through one of the
121 existing plans or by enrolling the Medicare-eligible
122 retired employees into a Medicare-specific plan,
123 including, but not limited to, the Medicare/Advantage
124 Prescription Drug Plan. In the event that a Medicare-
125 specific plan would no longer be available or
126 advantageous for the agency and the retirees, the
127 retirees shall remain eligible for coverage through the
128 agency.

§5-16-9. Authorization to execute contracts for group hospital and surgical insurance, group major medical insurance, group prescription drug insurance, group life and accidental death insurance and other accidental death insurance; mandated benefits; limitations; awarding of contracts; reinsurance; certificates for covered employees; discontinuance of contracts.

1 (a) The director is hereby given exclusive
2 authorization to execute such contract or contracts as
3 are necessary to carry out the provisions of this article
4 and to provide the plan or plans of group hospital and
5 surgical insurance coverage, group major medical
6 insurance coverage, group prescription drug insurance
7 coverage and group life and accidental death insurance
8 coverage selected in accordance with the provisions of
9 this article, such contract or contracts to be executed
10 with one or more agencies, corporations, insurance
11 companies or service organizations licensed to sell
12 group hospital and surgical insurance, group major
13 medical insurance, group prescription drug insurance
14 and group life and accidental death insurance in this
15 state.

16 (b) The group hospital or surgical insurance coverage
17 and group major medical insurance coverage herein
18 provided for shall include coverages and benefits for X-
19 ray and laboratory services in connection with
20 mammogram and pap smears when performed for
21 cancer screening or diagnostic services and annual
22 checkups for prostate cancer in men age fifty and over.
23 Such benefits shall include, but not be limited to, the
24 following:

25 (1) Mammograms when medically appropriate and
26 consistent with the current guidelines from the United
27 States Preventive Services Task Force;

28 (2) A pap smear, either conventional or liquid-based
29 cytology, whichever is medically appropriate and
30 consistent with the current guidelines from the United
31 States Preventative Services Task Force or The
32 American College of Obstetricians and Gynecologists,
33 for women age eighteen and over;

34 (3) A test for the human papilloma virus (HPV) for
35 women age eighteen or over, when medically
36 appropriate and consistent with the current guidelines
37 from either the United States Preventive Services Task
38 Force or The American College of Obstetricians and
39 Gynecologists for women age eighteen and over;

40 (4) A checkup for prostate cancer annually for men
41 age fifty or over; and

42 (5) Annual screening for kidney disease as determined
43 to be medically necessary by a physician using any
44 combination of blood pressure testing, urine albumin or
45 urine protein testing and serum creatinine testing as
46 recommended by the National Kidney Foundation.

47 (c) The group life and accidental death insurance
48 herein provided for shall be in the amount of ten
49 thousand dollars for every employee. The amount of the
50 group life and accidental death insurance to which an
51 employee would otherwise be entitled shall be reduced
52 to five thousand dollars upon such employee attaining

53 age sixty-five.

54 (d) All of the insurance coverage to be provided for
55 under this article may be included in one or more
56 similar contracts issued by the same or different
57 carriers.

58 (e) The provisions of article three, chapter five-a of
59 this code, relating to the Division of Purchasing of the
60 Department of Finance and Administration, shall not
61 apply to any contracts for any insurance coverage or
62 professional services authorized to be executed under
63 the provisions of this article. Before entering into any
64 contract for any insurance coverage, as authorized in
65 this article, the director shall invite competent bids
66 from all qualified and licensed insurance companies or
67 carriers, who may wish to offer plans for the insurance
68 coverage desired: *Provided,* That the director shall
69 negotiate and contract directly with health care
70 providers and other entities, organizations and vendors
71 in order to secure competitive premiums, prices and
72 other financial advantages. The director shall deal
73 directly with insurers or health care providers and other
74 entities, organizations and vendors in presenting
75 specifications and receiving quotations for bid
76 purposes. No commission or finder's fee, or any
77 combination thereof, shall be paid to any individual or
78 agent; but this shall not preclude an underwriting
79 insurance company or companies, at their own expense,
80 from appointing a licensed resident agent, within this
81 state, to service the companies' contracts awarded
82 under the provisions of this article. Commissions
83 reasonably related to actual service rendered for the
84 agent or agents may be paid by the underwriting
85 company or companies: *Provided, however,* That in no
86 event shall payment be made to any agent or agents
87 when no actual services are rendered or performed. The
88 director shall award the contract or contracts on a
89 competitive basis. In awarding the contract or
90 contracts the director shall take into account the
91 experience of the offering agency, corporation,
92 insurance company or service organization in the group
93 hospital and surgical insurance field, group major

94 medical insurance field, group prescription drug field
95 and group life and accidental death insurance field and
96 its facilities for the handling of claims. In evaluating
97 these factors, the director may employ the services of
98 impartial, professional insurance analysts or actuaries
99 or both. Any contract executed by the director with a
100 selected carrier shall be a contract to govern all eligible
101 employees subject to the provisions of this article.
102 Nothing contained in this article shall prohibit any
103 insurance carrier from soliciting employees covered
104 hereunder to purchase additional hospital and surgical,
105 major medical or life and accidental death insurance
106 coverage.

107 (f) The director may authorize the carrier with whom
108 a primary contract is executed to reinsure portions of
109 the contract with other carriers which elect to be a
110 reinsurer and who are legally qualified to enter into a
111 reinsurance agreement under the laws of this state.

112 (g) Each employee who is covered under any contract
113 or contracts shall receive a statement of benefits to
114 which the employee, his or her spouse and his or her
115 dependents are entitled under the contract, setting forth
116 the information as to whom the benefits are payable, to
117 whom claims shall be submitted and a summary of the
118 provisions of the contract or contracts as they affect the
119 employee, his or her spouse and his or her dependents.

120 (h) The director may at the end of any contract period
121 discontinue any contract or contracts it has executed
122 with any carrier and replace the same with a contract or
123 contracts with any other carrier or carriers meeting the
124 requirements of this article.

125 (i) The director shall provide by contract or contracts
126 entered into under the provisions of this article the cost
127 for coverage of children's immunization services from
128 birth through age sixteen years to provide
129 immunization against the following illnesses:
130 Diphtheria, polio, mumps, measles, rubella, tetanus,
131 hepatitis-b, haemophilus influenza-b and whooping
132 cough. Additional immunizations may be required by

133 the Commissioner of the Bureau for Public Health for
134 public health purposes. Any contract entered into to
135 cover these services shall require that all costs
136 associated with immunization, including the cost of the
137 vaccine, if incurred by the health care provider, and all
138 costs of vaccine administration, be exempt from any
139 deductible, per visit charge and/or copayment
140 provisions which may be in force in these policies or
141 contracts. This section does not require that other
142 health care services provided at the time of
143 immunization be exempt from any deductible and/or
144 copayment provisions.

CHAPTER 9. HUMAN SERVICES.

ARTICLE 5. MISCELLANEOUS PROVISIONS.

§9-5-20. Medicaid program; chronic kidney disease; evaluation and classification.

1 (a) Any enrollee in Medicaid who is eligible for
2 services and who has a diagnosis of diabetes or
3 hypertension or, who has a family history of kidney
4 disease, shall receive coverage for an evaluation for
5 chronic kidney disease through routine clinical
6 laboratory assessments of kidney function.

7 (b) Any enrollee in Medicaid who is eligible for
8 services and who has been diagnosed with diabetes or
9 hypertension or who has a family history of kidney
10 disease and who has received a diagnosis of kidney
11 disease shall be classified as a chronic kidney patient.

12 (c) The diagnostic criteria used to define chronic
13 kidney disease should be those generally recognized
14 through clinical practice guidelines which identify
15 chronic kidney disease or its complications based on the
16 presence of kidney damage and level of kidney function.

17 (d) Medicaid providers shall be educated by the
18 Bureau for Public Health in an effort to increase the
19 rate of evaluation and treatment for chronic kidney
20 disease. Providers should be made aware of:

21 (i) Managing risk factors, which prolong kidney
22 function or delay progression to kidney replacement
23 therapy;

24 (ii) Managing risk factors for bone disease and
25 cardiovascular disease associated with chronic kidney
26 disease;

27 (iii) Improving nutritional status of chronic kidney
28 disease patients; and

29 (iv) Correcting anemia associated with chronic kidney
30 disease.

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4i. Third-party reimbursement for kidney disease screening.

1 (a) Notwithstanding any provision of any policy,
2 provision, contract, plan or agreement applicable to this
3 article, reimbursement or indemnification for annual
4 kidney disease screening and laboratory testing as
5 recommended by the National Kidney Foundation may
6 not be denied for any person when reimbursement or
7 indemnity for laboratory or X-ray services are covered
8 under the policy and are performed for kidney disease
9 screening or diagnostic purposes at the direction of a
10 person licensed to practice medicine and surgery by the
11 board of medicine. The tests are as follows: Any
12 combination of blood pressure testing, urine albumin or
13 urine protein testing and serum creatinine testing.

14 (b) The same deductibles, coinsurance, network
15 restrictions and other limitations for covered services
16 found in the policy, provision, contract, plan or
17 agreement of the covered person may apply to kidney
18 disease screening and laboratory testing.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3s. Third-party reimbursement for kidney disease screening.

1 (a) Notwithstanding any provision of any policy,
2 provision, contract, plan or agreement applicable to this
3 article, reimbursement or indemnification for annual
4 kidney disease screening and laboratory testing as
5 recommended by the National Kidney Foundation may
6 not be denied for any person when reimbursement or
7 indemnity for laboratory or X-ray services are covered
8 under the policy and are performed for kidney disease
9 screening or diagnostic purposes at the direction of a
10 person licensed to practice medicine and surgery by the
11 board of medicine. The tests are as follows: Any
12 combination of blood pressure testing, urine albumin or
13 urine protein testing and serum creatinine testing.

14 (b) The same deductibles, coinsurance, network
15 restrictions and other limitations for covered services
16 found in the policy, provision, contract, plan or
17 agreement of the covered person may apply to kidney
18 disease screening and laboratory testing.

ARTICLE 33. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS AND HEALTH SERVICE CORPORATIONS.

§33-24-7i. Third-party reimbursement for kidney disease screening.

1 (a) Notwithstanding any provision of any policy,
2 provision, contract, plan or agreement applicable to this
3 article, reimbursement or indemnification for annual
4 kidney disease screening and laboratory testing as
5 recommended by the National Kidney Foundation may
6 not be denied for any person when reimbursement or
7 indemnity for laboratory or X-ray services are covered
8 under the policy and are performed for kidney disease
9 screening or diagnostic purposes at the direction of a
10 person licensed to practice medicine and surgery by the
11 board of medicine. The tests are as follows: Any
12 combination of blood pressure testing, urine albumin or
13 urine protein testing and serum creatinine testing.

14 (b) The same deductibles, coinsurance, network
15 restrictions and other limitations for covered services
16 found in the policy, provision, contract, plan or
17 agreement of the covered person may apply to kidney
18 disease screening and laboratory testing.

ARTICLE 25. HEALTH CARE CORPORATION.

§33-25-8g. Third-party reimbursement for kidney disease screening.

1 (a) Notwithstanding any provision of any policy,
2 provision, contract, plan or agreement applicable to this
3 article, reimbursement or indemnification for annual
4 kidney disease screening and laboratory testing as
5 recommended by the National Kidney Foundation may
6 not be denied for any person when reimbursement or
7 indemnity for laboratory or X-ray services are covered
8 under the policy and are performed for kidney disease
9 screening or diagnostic purposes at the direction of a
10 person licensed to practice medicine and surgery by the
11 board of medicine. The tests are as follows: Any
12 combination of blood pressure testing, urine albumin or
13 urine protein testing and serum creatinine testing.

14 (b) The same deductibles, coinsurance, network
15 restrictions and other limitations for covered services
16 found in the policy, provision, contract, plan or
17 agreement of the covered person may apply to kidney
18 disease screening and laboratory testing.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8h. Third-party reimbursement for kidney disease screening.

1 (a) Notwithstanding any provision of any policy,
2 provision, contract, plan or agreement applicable to this
3 article, reimbursement or indemnification for annual
4 kidney disease screening and laboratory testing as
5 recommended by the National Kidney Foundation may
6 not be denied for any person when reimbursement or
7 indemnity for laboratory or X-ray services are covered

8 under the policy and are performed for kidney disease
9 screening or diagnostic purposes at the direction of a
10 person licensed to practice medicine and surgery by the
11 board of medicine. The tests are as follows: Any
12 combination of blood pressure testing, urine albumin or
13 urine protein testing and serum creatinine testing.

14 (b) The same deductibles, coinsurance, network
15 restrictions and other limitations for covered services
16 found in the policy, provision, contract, plan or
17 agreement of the covered person may apply to kidney
18 disease screening and laboratory testing.

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

....
Chairman Senate Committee

....
Chairman House Committee

Originated in the Senate.

In effect ninety days from passage.

....
Clerk of the Senate

....
Clerk of the House of Delegates

....
President of the Senate

....
Speaker House of Delegates

The within ......is approved...................... this the ..26... Day of ....March.........................., 2007.

....
Governor

PRESENTED TO THE
GOVERNOR

MAR 20 2007

Time 3:30pm