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.]
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
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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 when medically appropriate and consistent with current guidelines from the United States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists; and a test for the human papilloma virus (HPV) when medically appropriate and consistent with current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists, when performed for cancer screening or diagnostic services on a woman age eighteen or over;

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

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

(5) 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

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

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

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

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

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

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

(c) The group life and accidental death insurance herein provided for shall be in the amount of ten thousand dollars for every employee. The amount of the group life and accidental death insurance to which an employee would otherwise be entitled shall be reduced 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
directly with insurers or health care providers and other
entities, organizations and vendors in presenting
specifications and receiving quotations for bid
purposes. No commission or finder’s fee, or any
combination thereof, shall be paid to any individual or
agent; but this shall not preclude an underwriting
insurance company or companies, at their own expense,
from appointing a licensed resident agent, within this
state, to service the companies’ contracts awarded
under the provisions of this article. Commissions
reasonably related to actual service rendered for the
agent or agents may be paid by the underwriting
company or companies: Provided, however, That in no
event shall payment be made to any agent or agents
when no actual services are rendered or performed. The
director shall award the contract or contracts on a
competitive basis. In awarding the contract or
contracts the director shall take into account the
experience of the offering agency, corporation,
insurance company or service organization in the group
hospital and surgical insurance field, group major
medical insurance field, group prescription drug field
and group life and accidental death insurance field and
its facilities for the handling of claims. In evaluating
these factors, the director may employ the services of
impartial, professional insurance analysts or actuaries
or both. Any contract executed by the director with a
selected carrier shall be a contract to govern all eligible
employees subject to the provisions of this article.
Nothing contained in this article shall prohibit any
insurance carrier from soliciting employees covered
hereunder to purchase additional hospital and surgical,
major medical or life and accidental death insurance
coverage.

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

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

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

(i) The director shall provide by contract or contracts
entered into under the provisions of this article the cost
for coverage of children's immunization services from
birth through age sixteen years to provide
immunization against the following illnesses:
Diphtheria, polio, mumps, measles, rubella, tetanus,
hepatitis-b, haemophilus influenza-b and whooping
cough. Additional immunizations may be required by
the Commissioner of the Bureau for Public Health for public health purposes. Any contract entered into to cover these services shall require that all costs associated with immunization, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration, be exempt from any deductible, per visit charge and/or copayment provisions which may be in force in these policies or contracts. This section does not require that other health care services provided at the time of immunization be exempt from any deductible and/or copayment provisions.

CHAPTER 9. HUMAN SERVICES.

ARTICLE 5. MISCELLANEOUS PROVISIONS.

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

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

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

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

(d) Medicaid providers shall be educated by the Bureau for Public Health in an effort to increase the rate of evaluation and treatment for chronic kidney disease. Providers should be made aware of:
(i) Managing risk factors, which prolong kidney function or delay progression to kidney replacement;

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

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

(iv) Correcting anemia associated with chronic kidney disease.

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

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

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

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

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.
§33-16-3s. Third-party reimbursement for kidney disease screening.

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

(b) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered person may apply to kidney 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.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, reimbursement or indemnification for annual kidney disease screening and laboratory testing as recommended by the National Kidney Foundation may not be denied for any person when reimbursement or indemnity for laboratory or X-ray services are covered under the policy and are performed for kidney disease screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery by the board of medicine. The tests are as follows: Any combination of blood pressure testing, urine albumin or urine protein testing and serum creatinine testing.
ARTICLE 25. HEALTH CARE CORPORATION.

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

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

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

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

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

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

(b) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered person may apply to kidney 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 26th Day of March 2007.

Governor
PRESENTED TO THE GOVERNOR

MAR 20 2007

Time 3:30 PM