

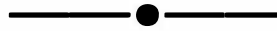
HB 3288

FILED

2009 JUN -5 PM 4: 08

OFFICE WEST VIRGINIA
SECRETARY OF STATE

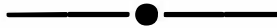
WEST VIRGINIA LEGISLATURE
FIRST REGULAR SESSION, 2009



**SECOND
ENROLLMENT**

**COMMITTEE SUBSTITUTE
FOR
House Bill No. 3288**

(By Delegates Perry, Shaver, Ashley and Moore)



Amended and again passed May 27, 2009,
as a result of the objections of the Governor

In Effect Ninety Days From Passage

S E C O N D
E N R O L L M E N T

COMMITTEE SUBSTITUTE

FOR

H. B. 3288

(BY DELEGATES PERRY, SHAVER, ASHLEY AND MOORE)

[Amended and again passed May 27, 2009, as a result of the objections of the Governor; in effect ninety days from passage.]

AN ACT to amend and reenact §5-16-7 of the Code of West Virginia, 1931, as amended, and to amend and reenact §33-16-3a of said code, all relating to group accident and sickness insurance requirements to cover treatment of mental illness; providing that actual increases in costs for certain coverage determine whether cost containment measures may be applied by Public Employees Insurance Agency and private carriers; and removing certain provisions regarding small groups.

Be it enacted by the Legislature of West Virginia:

That §5-16-7 of the Code of West Virginia, 1931, as amended, be amended and reenacted; and that §33-16-3a of said code be amended and reenacted, all to read as follows:

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

9 (1) Coverages and benefits for X ray and laboratory
10 services in connection with mammograms when medically
11 appropriate and consistent with current guidelines from the
12 United States Preventive Services Task Force; pap smears,
13 either conventional or liquid-based cytology, whichever is
14 medically appropriate and consistent with the current
15 guidelines from either the United States Preventive Services
16 Task Force or The American College of Obstetricians and
17 Gynecologists; and a test for the human papilloma virus
18 (HPV) when medically appropriate and consistent with

19 current guidelines from either the United States Preventive
20 Services Task Force or The American College of
21 Obstetricians and Gynecologists, when performed for cancer
22 screening or diagnostic services on a woman age eighteen or
23 over;

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

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

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

41 (5) For plans which provide coverages for post-delivery
42 care to a mother and her newly born child in the home,
43 coverage for inpatient care following childbirth as provided
44 in subdivision (4) of this subsection if inpatient care is
45 determined to be medically necessary by the attending
46 physician. Those plans may also include, among other
47 things, medicines, medical equipment, prosthetic appliances
48 and any other inpatient and outpatient services and expenses
49 considered appropriate and desirable by the agency; and

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

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

65 (B) Notwithstanding any other provision in this section
66 to the contrary, in the event that the agency can demonstrate
67 that its total costs for the treatment of mental illness for any
68 plan exceeded two percent of the total costs for such plan in
69 any experience period, then the agency may apply whatever
70 additional cost-containment measures may be necessary,
71 including, but not limited to, limitations on inpatient and
72 outpatient benefits, to maintain costs below two percent of
73 the total costs for the plan for the next experience period.

74 (C) The agency shall not discriminate between
75 medical-surgical benefits and mental health benefits in the
76 administration of its plan. With regard to both
77 medical-surgical and mental health benefits, it may make
78 determinations of medical necessity and appropriateness, and
79 it may use recognized health care quality and cost
80 management tools, including, but not limited to, limitations
81 on inpatient and outpatient benefits, utilization review,
82 implementation of cost-containment measures,

83 preauthorization for certain treatments, setting coverage
84 levels, setting maximum number of visits within certain time
85 periods, using capitated benefit arrangements, using
86 fee-for-service arrangements, using third-party
87 administrators, using provider networks and using patient
88 cost sharing in the form of copayments, deductibles and
89 coinsurance.

90 (7) Coverage for general anesthesia for dental
91 procedures and associated outpatient hospital or ambulatory
92 facility charges provided by appropriately licensed health
93 care individuals in conjunction with dental care if the covered
94 person is:

95 (A) Seven years of age or younger or is developmentally
96 disabled, and is an individual for whom a successful result
97 cannot be expected from dental care provided under local
98 anesthesia because of a physical, intellectual or other
99 medically compromising condition of the individual and for
100 whom a superior result can be expected from dental care
101 provided under general anesthesia;

102 (B) A child who is twelve years of age or younger with
103 documented phobias, or with documented mental illness, and
104 with dental needs of such magnitude that treatment should
105 not be delayed or deferred and for whom lack of treatment
106 can be expected to result in infection, loss of teeth or other
107 increased oral or dental morbidity and for whom a successful
108 result cannot be expected from dental care provided under
109 local anesthesia because of such condition and for whom a
110 superior result can be expected from dental care provided
111 under general anesthesia.

112 (b) The agency shall make available to each eligible
113 employee, at full cost to the employee, the opportunity to
114 purchase optional group life and accidental death insurance

115 as established under the rules of the agency. In addition,
116 each employee is entitled to have his or her spouse and
117 dependents, as defined by the rules of the agency, included in
118 the optional coverage, at full cost to the employee, for each
119 eligible dependent; and with full authorization to the agency
120 to make the optional coverage available and provide an
121 opportunity of purchase to each employee.

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

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

125 (2) All teaching and professional employees of state
126 public institutions of higher education and county boards of
127 education;

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

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

134 (d) The agency shall maintain the medical and
135 prescription drug coverage for Medicare-eligible retirees by
136 providing coverage through one of the existing plans or by
137 enrolling the Medicare-eligible retired employees into a
138 Medicare-specific plan, including, but not limited to, the
139 Medicare/Advantage Prescription Drug Plan. In the event
140 that a Medicare-specific plan would no longer be available or
141 advantageous for the agency and the retirees, the retirees
142 shall remain eligible for coverage through the agency.

CHAPTER 33. INSURANCE.

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

§33-16-3a. Same -- Mental health.

1 (a) (1) Notwithstanding the requirements of subsection
2 (b) of this section, any health benefits plan described in this
3 article that is delivered, issued or renewed in this state shall
4 provide benefits to all individual subscribers and members
5 and to all group members for expenses arising from treatment
6 of serious mental illness. The expenses do not include
7 custodial care, residential care or schooling. For purposes of
8 this section, "serious mental illness" means an illness
9 included in the American Psychiatric Association's
10 Diagnostic and Statistical Manual of Mental Disorders, as
11 periodically revised, under the diagnostic categories or
12 subclassifications of: (A) Schizophrenia and other psychotic
13 disorders; (B) bipolar disorders; (C) depressive disorders; (D)
14 substance-related disorders with the exception of
15 caffeine-related disorders and nicotine-related disorders; (E)
16 anxiety disorders; and (F) anorexia and bulimia.

17 (2) Notwithstanding any other provision in this section
18 to the contrary, in the event that an insurer can demonstrate
19 actuarially to the Insurance Commissioner that its total
20 anticipated costs for treatment for mental illness, for any plan
21 will exceed or have exceeded two percent of the total costs
22 for such plan in any experience period, then the insurer may
23 apply whatever cost containment measures may be necessary,
24 including, but not limited to, limitations on inpatient and
25 outpatient benefits, to maintain costs below two percent of
26 the total costs for the plan: *Provided*, That for any plan year
27 beginning on or after October 3, 2009, an insurer providing
28 a "group health plan," as defined in section one-a of this
29 article, with an average of more than fifty employees on

30 business days during the preceding calendar year, may not
31 apply cost containment measures as provided in this
32 subdivision unless the insurer can demonstrate that the
33 application of this section results in an increase of two
34 percent of the actual total costs of coverage for the plan year
35 involved with respect to medical-surgical benefits and mental
36 health benefits under the plan: *Provided, however,* That such
37 cost containment measures implemented are applicable only
38 for the plan year following approval of the request to
39 implement cost containment measures.

40 (3) The insurer shall not discriminate between
41 medical-surgical benefits and mental health benefits in the
42 administration of its plan. With regard to both
43 medical-surgical and mental health benefits, it may make
44 determinations of medical necessity and appropriateness, and
45 it may use recognized health care quality and cost
46 management tools, including, but not limited to, utilization
47 review, use of provider networks, implementation of cost
48 containment measures, preauthorization for certain
49 treatments, setting coverage levels including the number of
50 visits in a given time period, using capitated benefit
51 arrangements, using fee-for-service arrangements, using
52 third-party administrators, and using patient cost sharing in
53 the form of copayments, deductibles and coinsurance.

54 (4) The amendments to this subsection enacted during
55 the regular session of the Legislature in the year 2009 shall
56 apply with respect to group health plans for plan years
57 beginning on or after October 3, 2009.

58 (b) With respect to mental health benefits furnished to
59 an enrollee of a health benefit plan offered in connection with
60 a group health plan, for a plan year beginning on or after
61 January 1, 1998, the following requirements shall apply to
62 aggregate lifetime limits and annual limits.

63 (1) Aggregate lifetime limits:

64 (A) If the health benefit plan does not include an
65 aggregate lifetime limit on substantially all medical and
66 surgical benefits, as defined under the terms of the plan but
67 not including mental health benefits, the plan may not impose
68 any aggregate lifetime 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
71 unit 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
75 health benefits, as defined under the terms of the plan, and
76 not distinguish in the application of the limit between medical
77 and surgical benefits and mental health benefits, or not
78 include any aggregate lifetime limit on mental health benefits
79 that is less than the applicable lifetime limit;

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

88 (2) Annual limits:

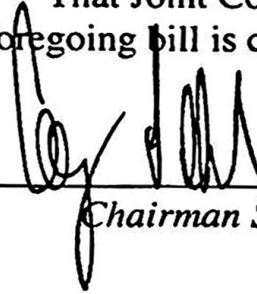
89 (A) If a health benefit plan does not include an annual
90 limit on substantially all medical and surgical benefits, as
91 defined under the terms of the plan but not including mental
92 health benefits, the plan may not impose any annual limit on
93 mental health benefits, as defined under the terms 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
99 to medical and surgical benefits to which it would otherwise
100 apply and to mental health benefits, as defined under the
101 terms of the plan, and not distinguish in the application of the
102 limit between medical and surgical benefits and mental health
103 benefits, or not include any annual limit on mental health
104 benefits that is less than the applicable annual limit;

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

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

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.

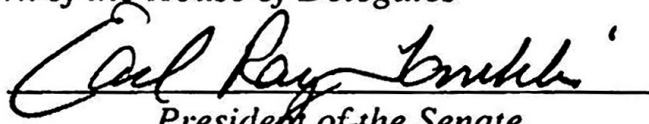
In effect ninety days from passage.



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 5th
day of June, 2009.



Governor

PRESENTED TO THE
GOVERNOR

JUN - 1 2009

Time 10:10am