HB 3288 (veto)

WEST VIRGINIA LEGISLATURE

FIRST REGULAR SESSION, 2009

ENROLLED

COMMITTEE SUBSTITUTE
FOR
House Bill No. 3288

(By Delegates Perry, Shaver, Ashley and Moore)

Passed April 10, 2009

In Effect Ninety Days from Passage

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COMMITTEE SUBSTITUTE

FOR

H. B. 3288

(BY DELEGATES PERRY, SHAVER, ASHLEY AND MOORE)

[Passed April 10, 2009; 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:

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 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 a plan may not 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 (4) 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 that its total costs for the treatment of mental illness for any plan exceed two percent of the total costs for such plan in any experience period, then the agency may apply whatever additional 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 for the next experience period.

(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 education and county boards of education;

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

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

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

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: (A) Schizophrenia and other psychotic disorders; (B) bipolar disorders; (C) depressive disorders; (D) substance-related disorders with the exception of caffeine-related disorders and nicotine-related disorders; (E) anxiety disorders; and (F) 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 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: *Provided,* That for any plan year beginning after October 3, 2009, an insurer providing a "group health plan," as defined in section one-a of this article, with an average of more than fifty employees on business days during the preceding calendar year, may not apply cost containment measures as provided in this subdivision unless the insurer can demonstrate that the application of this section results in an increase of two percent of the actual total costs of coverage for the plan year involved with respect to medical-surgical benefits and mental health benefits under the plan: *Provided, however,* That such cost containment measures implemented are applicable only for the plan year following approval of the request to implement cost containment measures.

(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 amendments to this subsection shall apply with respect to group health plans for plan years beginning on or after October 3, 2009.

(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 January 1, 1998, 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.

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 disapproved this the 4th day of May, 2009.

Governor

PRESENTED TO THE
GOVERNOR

APR 29 2009

Time 11:35 AM