2011R2110SI

Senate Bill No. 218

(By Senators Jenkins, Kessler (Acting President), Palumbo, Stollings, Williams, Yost, Browning, Wells, Plymale, Laird, Miler Fanning, Minard and Klempa)

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[Introduced January 19, 2011; referred to the Committee pm Banking and Insurance; and then to the Committee on Finance.]

Interim Bill

FISCAL NOTE

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A BILL 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 requiring insurance coverage for autism spectrum disorders.

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

1 **accidental death insurance plan; rules for**
2 **administration of plans; mandated benefits; what plans**
3 **may provide; optional plans; separate rating for**
4 **claims experience purposes.**

5 (a) The agency shall establish a group hospital and surgical
6 insurance plan or plans, a group prescription drug insurance plan
7 or plans, a group major medical insurance plan or plans and a group
8 life and accidental death insurance plan or plans for those
9 employees herein made eligible, and to establish and promulgate
10 rules for the administration of these plans, subject to the
11 limitations contained in this article. Those plans shall include:

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

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

27 (3) Annual screening for kidney disease as determined to be

1 medically necessary by a physician using any combination of blood
2 pressure testing, urine albumin or urine protein testing and serum
3 creatinine testing as recommended by the National Kidney
4 Foundation;

5 (4) For plans that include maternity benefits, coverage for
6 inpatient care in a duly licensed health care facility for a mother
7 and her newly born infant for the length of time which the
8 attending physician considers medically necessary for the mother or
9 her newly born child: *Provided,* That no plan may deny payment for
10 a mother or her newborn child prior to forty-eight hours following
11 a vaginal delivery, or prior to ninety-six hours following a
12 caesarean section delivery, if the attending physician considers
13 discharge medically inappropriate;

14 (5) For plans which provide coverages for post-delivery care
15 to a mother and her newly born child in the home, coverage for
16 inpatient care following childbirth as provided in subdivision (4)
17 of this subsection if inpatient care is determined to be medically
18 necessary by the attending physician. Those plans may also
19 include, among other things, medicines, medical equipment,
20 prosthetic appliances and any other inpatient and outpatient
21 services and expenses considered appropriate and desirable by the
22 agency; and

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

24 (A) The coverage does not include custodial care, residential
25 care or schooling. For purposes of this section, "serious mental
26 illness" means an illness included in the American Psychiatric
27 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; and (vii) autism spectrum disorders. 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 exceeded 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. However, these limits may be imposed only in so far as they are not in conflict with the provisions of the Patient Protection and Affordable Care Act, P.L. 111-148.

(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

1 cost management tools, including, but not limited to, limitations
2 on inpatient and outpatient benefits, utilization review,
3 implementation of cost-containment measures, preauthorization for
4 certain treatments, setting coverage levels, setting maximum number
5 of visits within certain time periods, using capitated benefit
6 arrangements, using fee-for-service arrangements, using third-party
7 administrators, using provider networks and using patient cost
8 sharing in the form of copayments, deductibles and coinsurance.
9 However, these limits may be imposed only in so far as they are not
10 in conflict with the provisions of the Patient Protection and
11 Affordable Care Act, P.L. 111-148. For purposes of this section,
12 applied behavioral analysis is a medically necessary evidence-based
13 treatment for serious mental illnesses, including autism spectrum
14 disorders.
15 (7) Coverage for general anesthesia for dental procedures and
16 associated outpatient hospital or ambulatory facility charges
17 provided by appropriately licensed health care individuals in
18 conjunction with dental care if the covered person is:
19 (A) Seven years of age or younger or is developmentally
20 disabled, and is an individual for whom a successful result cannot
21 be expected from dental care provided under local anesthesia
22 because of a physical, intellectual or other medically compromising
23 condition of the individual and for whom a superior result can be
24 expected from dental care provided under general anesthesia;
25 (B) A child who is twelve years of age or younger with
26 documented phobias, or with documented mental illness, and with
27 dental needs of such magnitude that treatment should not be delayed

1 or deferred and for whom lack of treatment can be expected to
2 result in infection, loss of teeth or other increased oral or
3 dental morbidity and for whom a successful result cannot be
4 expected from dental care provided under local anesthesia because
5 of such condition and for whom a superior result can be expected
6 from dental care provided under general anesthesia.

7 (b) The agency shall make available to each eligible employee,
8 at full cost to the employee, the opportunity to purchase optional
9 group life and accidental death insurance as established under the
10 rules of the agency. In addition, each employee is entitled to
11 have his or her spouse and dependents, as defined by the rules of
12 the agency, included in the optional coverage, at full cost to the
13 employee, for each eligible dependent; and with full authorization
14 to the agency to make the optional coverage available and provide
15 an opportunity of purchase to each employee.

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

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

19 (2) All teaching and professional employees of state public
20 institutions of higher education and county boards of education;

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

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

26 (d) The agency shall maintain the medical and prescription
27 drug coverage for Medicare-eligible retirees by providing coverage

1 through one of the existing plans or by enrolling the Medicare-
2 eligible retired employees into a Medicare-specific plan,
3 including, but not limited to, the Medicare/Advantage Prescription
4 Drug Plan. In the event that a Medicare-specific plan would no
5 longer be available or advantageous for the agency and the
6 retirees, the retirees shall remain eligible for coverage through
7 the agency.

8 **CHAPTER 33. INSURANCE.**

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

10 **§33-16-3a. Same -- Mental health.**

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

26 (2) Notwithstanding any other provision in this section to the
27 contrary, in the event that an insurer can demonstrate actuarially

1 to the Insurance Commissioner that its total anticipated costs for
2 treatment for mental illness, for any plan will exceed or have
3 exceeded two percent of the total costs for such plan in any
4 experience period, then the insurer may apply whatever cost
5 containment measures may be necessary, including, but not limited
6 to, limitations on inpatient and outpatient benefits, to maintain
7 costs below two percent of the total costs for the plan: *Provided,*
8 That for any plan year beginning on or after October 3, 2009, an
9 insurer providing a "group health plan," as defined in section
10 one-a of this article, with an average of more than fifty employees
11 on business days during the preceding calendar year, may not apply
12 cost containment measures as provided in this subdivision unless
13 the insurer can demonstrate that the application of this section
14 results in an increase of two percent of the actual total costs of
15 coverage for the plan year involved with respect to
16 medical-surgical benefits and mental health benefits under the
17 plan: *Provided, however,* That such cost containment measures
18 implemented are applicable only for the plan year following
19 approval of the request to implement cost containment measures;
20 *Provided further,* That these limits may be imposed only in so far
21 as they are not in conflict with the provisions of the Patient
22 Protection and Affordable Care Act, P.L. 111-148.

23 (3) The insurer shall not discriminate between
24 medical-surgical benefits and mental health benefits in the
25 administration of its plan. With regard to both medical-surgical
26 and mental health benefits, it may make determinations of medical
27 necessity and appropriateness, and it may use recognized health

1 care quality and cost management tools, including, but not limited
2 to, utilization review, use of provider networks, implementation of
3 cost containment measures, preauthorization for certain treatments,
4 setting coverage levels including the number of visits in a given
5 time period, using capitated benefit arrangements, using
6 fee-for-service arrangements, using third-party administrators, and
7 using patient cost sharing in the form of copayments, deductibles
8 and coinsurance. <u>However, these limits may be imposed only in so</u>
9 <u>far as they are not in conflict with the provisions of the Patient</u>
10 <u>Protection and Affordable Care Act, P.L. 111-148. For purposes of</u>
11 <u>this section, applied behavioral analysis is a medically necessary</u>
12 <u>evidence-based treatment for several serious illnesses, including</u>
13 <u>autism spectrum disorders.</u>
14 (4) The amendments to this subsection enacted during the
15 regular session of the Legislature in the year 2009 shall apply
16 with respect to group health plans for plan years beginning on or
17 after October 3, 2009.
18 (b) With respect to mental health benefits furnished to an
19 enrollee of a health benefit plan offered in connection with a
20 group health plan, for a plan year beginning on or after January 1,
21 1998, the following requirements shall apply to aggregate lifetime
22 limits and annual limits.
23 (1) Aggregate lifetime limits:
24 (A) If the health benefit plan does not include an aggregate
25 lifetime limit on substantially all medical and surgical benefits,
26 as defined under the terms of the plan but not including mental
27 health benefits, the plan may not impose any aggregate lifetime

1 limit on mental health benefits;

2 (B) If the health benefit plan limits the total amount that
3 may be paid with respect to an individual or other coverage unit
4 for substantially all medical and surgical benefits (in this
5 paragraph, "applicable lifetime limit"), the plan shall either
6 apply the applicable lifetime limit to medical and surgical
7 benefits to which it would otherwise apply and to mental health
8 benefits, as defined under the terms of the plan, and not
9 distinguish in the application of the limit between medical and
10 surgical benefits and mental health benefits, or not include any
11 aggregate lifetime limit on mental health benefits that is less
12 than the applicable lifetime limit. However, these limits may be
13 imposed only in so far as they are not in conflict with the
14 provisions of the Patient Protection and Affordable Care Act, P.L.
15 111-148;

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

24 (2) Annual limits:

25 (A) If a health benefit plan does not include an annual limit
26 on substantially all medical and surgical benefits, as defined
27 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. However, these limits may be imposed only in so far as they are not in conflict with the provisions of the Patient Protection and Affordable Care Act, P.L. 111-148.

(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.

NOTE: The purpose of this bill is to require insurance coverage for autism spectrum disorders. The bill also ensures any limitations to coverage does not conflict with other applicable law.

Strike-throughs indicate language that would be stricken from the present law, and underscoring indicates new language that would be added.

This bill is recommenced for passage during the 2011 Regular Legislative Session by the Judiciary Subcommittee C.