# WEST VIRGINIA LEGISLATURE

## 2020 REGULAR SESSION

## Committee Substitute

## for

# House Bill 4543

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[Originating in the Committee on Health and Human

Resources; January 22, 2020.]

1 A BILL to repeal an article designated §33-15C-1 of the Code of West Virginia, 1931, as amended;
2 to amend said code by repealing one section , designated §33-16-16, of said code; to
3 amend said code by adding thereto a new article designated, §33-53-1, of said code; and
4 to amend and reenact two sections designated §5A-3-1a and §5-16-7, of said code, all
5 relating to insurance coverage for diabetics.

*Be it enacted by the Legislature of West Virginia:*

# CHAPTER 33. INSURANCE.

## ARTICLE 15C. DIABETES INSURANCE.

### §33-15C-1. Insurance for diabetics.

1 [Repealed]

## ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

### §33-16-16. Insurance for diabetics.

1 [Repealed]

## ARTICLE 53. REQUIRED COVERAGE FOR HEALTH INSURANCE.

### §33-53-1. Cost sharing in prescription insulin drugs.

1 *(a) Findings. –*
2 (1) It is estimated that over 240,000 West Virginian's are diagnosed and living with type 1
3 or type 2 diabetes and another 65,000 are undiagnosed;
4 (2) Every West Virginian with type 1 diabetes and many with type 2 diabetes rely on daily
5 doses of insulin to survive;
6 (3) The annual medical cost related to diabetes in West Virginia is estimated at $2.5 billion
7 annually;
8 (4) Persons diagnosed with diabetes will incur medical costs approximately 2.3 times
9 higher than persons without diabetes;

10 (5) The cost of insulin has increased astronomically, especially the cost of insurance co-
11 payments, which can exceed $600 per month. Similar increases in the cost of diabetic equipment
12 and supplies, and insurance premiums has resulted in out-of-pocket costs for many West
13 Virginian diabetics in excess of $1,000 per month;
14 (6) National reports indicate as many as one in four type 1 diabetics underuse, or ration,
15 insulin due these increased costs. Rationing insulin has resulted in nerve damage, diabetic
16 comas, amputation, kidney damage, and even death; and
17 (7) It is important to enact policies to reduce the costs for West Virginians with diabetes to
18 obtain lifesaving and life-sustaining insulin.
19 (b) As used in this section:
20 (1) "Cost-sharing payment" means the total amount a covered person is required to pay
21 at the point of sale in order to receive a prescription drug that is covered under the covered
22 person's health plan.
23 (2) "Covered person" means a policyholder, subscriber, participant, or other individual
24 covered by a health plan.
25 (3) "Health plan" means any health benefit plan, as defined in §33-16-1a (h), that
26 provides coverage for a prescription insulin drug.
27 (4) "Pharmacy benefits manager" means an entity that engages in the administration or
28 management of prescription drug benefits provided by an insurer for the benefit of its covered
29 persons.
30 (5) "Prescription insulin drug" means a prescription drug that contains insulin and is used
31 to treat diabetes. ~~"Prescription insulin drug" means a drug containing insulin and is used to control~~
32 ~~blood glucose level to treat diabetes.~~
33 (c) Each health plan shall cover at least one type of insulin in all the following categories:
34 (1) Rapid-acting;
35 (2) Short-acting;

36 (3) Intermediate-acting;

37 (4) Long-acting;

38 (5) Pre-mixed insulin products;

39 (6) Pre-mixed insulin/GLP-1 RA products;

40 (7) Concentrated human regular insulin.

41 (d) Notwithstanding the provisions of §33-1-1 *et seq.* of this code, an insurer subject to §5-
42 16-1 *et seq.*, §33-15-1 *et seq.*, §33-16-1 *et seq.*, §33-24-1 *et seq.*, §33-25-1 *et seq.*, and §33-
43 25A-1 of this code which issues or renews a health insurance policy on or after July 1, 2020, shall
44 provide coverage for prescription insulin drugs pursuant to this section.

45 (e) Cost sharing for a 30-day supply of a covered prescription insulin drug shall not exceed
46 $25 for a 30-day supply of a covered prescription insulin ~~drug~~, regardless of the quantity or type
47 of prescription insulin ~~drug~~ used to fill the covered person's prescription needs.

48 (f) Nothing in this section prevents an insurer from reducing a covered person's cost
49 sharing to an amount less than the amount specified in subsection (e) of this section. ~~by an~~
50 ~~amount greater than amount specified in this subsection.~~

51 (g) No contract between an insurer subject to §5-16-1 *et seq.*, §33-15-1 *et seq.*, §33-16-
52 1 *et seq.*, §33-24-1 *et seq.*, §33-25-1 *et seq.*, and §33-25A-1 or its pharmacy benefits manager
53 and a pharmacy or its contracting agent shall contain a provision: (i) authorizing the insurer's
54 pharmacy benefits manager or the pharmacy to charge, (ii) requiring the pharmacy to collect, or
55 (iii) requiring a covered person to make a cost-sharing payment for a covered prescription insulin
56 drug in an amount that exceeds the amount of the cost-sharing payment for the covered
57 prescription insulin drug established by the insurer pursuant to subsection (d). ~~A drug~~
58 ~~manufacturer, drug wholesaler, or pharmacy benefit manager may not pass through the costs of~~
59 ~~the prescription insulin drug to the pharmacist or pharmacy. The commissioner may use any of~~
60 ~~the commissioner's enforcement powers to obtain an insurer's or pharmaceutical benefit~~
61 ~~manager's compliance with this section.~~

62 (h) An insurer subject to §5-16-1 *et seq.*, §33-15-1 *et seq.*, §33-16-1 *et seq.*, §33-24-1 *et*
63 *seq.*, §33-25-1 *et seq.*, and §33-25A-1 shall provide coverage for the following equipment and
64 supplies for the treatment and/or management of diabetes for both insulin dependent and
65 noninsulin dependent persons with diabetes and those with gestational diabetes: blood glucose
66 monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices,
67 pharmacological agents for controlling blood sugar and orthotics.
68 (i) An insurer subject to §5-16-1 *et seq.*, §33-15-1 *et seq.*, §33-16-1 *et seq.*, §33-24-1 *et*
69 *seq.*, §33-25-1 *et seq.*, and §33-25A-1 shall include coverage for diabetes self-management
70 education to ensure that persons with diabetes are educated as to the proper self-management
71 and treatment of their diabetes, including information on proper diets.
72 (j) All health care plans must offer an appeals process for persons who are not able to
73 take one or more of the offered prescription insulin drugs noted in subsection (c). The appeals
74 process shall be provided to covered persons in writing and afford covered persons and their
75 health care providers a meaningful opportunity to participate with covered persons healthcare
76 providers.
77 (k) Diabetes self-management education shall be provided by a health care practitioner
78 who has been appropriately trained. The Secretary of the Department of Health and Human
79 Services shall promulgate legislative rules to implement training requirements and procedures
80 necessary to fulfill provisions of this subsection: *Provided,* That any rules promulgated by the
81 Secretary shall be done after consultation with the Coalition for Diabetes Management, as
82 established in §16-5Z-1, *et seq.* of this code.
83 ~~Coverage for self-management education and education relating to diet shall be limited~~
84 ~~to:~~
85 ~~(1) Visits medically necessary upon the diagnosis of diabetes;~~

~~(2) Visits under circumstances where a health care practitioner identifies or diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management; and~~

~~(3) Where a new medication or therapeutic process relating to the person's treatment and/or management of diabetes has been identified as medically necessary by a health care practitioner: *Provided*, That coverage for reeducation or refresher education shall be limited to $100 annually.~~

~~(i) The education may be provided by a health care practitioner as part of an office visit for diabetes diagnosis or treatment, or by a licensed pharmacist for instructing and monitoring a patient regarding the proper use of covered equipment, supplies and medications, or by a certified diabetes educator, or registered dietitian.~~

# CHAPTER 5A. DEPARTMENT OF ADMINSTRATION.

## ARTICLE 3. PURCHASING DIVISION.

### §5A-3-1a. Prescription drug products.

(a) In addition to other provisions of this article, the division is authorized, on behalf of the Public Employees Insurance Agency, the schools of medicine of the state colleges and universities, the ~~department~~ division of vocational rehabilitation and the Department of Health and Human Resources, to negotiate and enter into agreements directly with manufacturers and distributors whose prescription drug products are sold in the state for sole-source and multiple-source drugs to be paid for under state program for eligible recipients. Such agreements shall provide for a rebate of a negotiated percentage of the total product cost to be paid by the manufacturer or distributor of the specific product. Each agency is authorized to establish, either singularly or together with other agencies, a drug formulary.

Prescription drug products are included in the drug formulary only upon completion of the application to and approval of the division. Those products for which a rebate is successfully

negotiated are automatically included in the drug formulary for a period of time coterminous with the negotiated rebate.

If there has been a failure to negotiate or renew a rebate agreement for a specific prescription drug product, the pharmaceutical manufacturer of that product shall disclose to the division its most favorable pricing arrangements available to state and nonstate government purchasers. If the division determines that the product needs to be included in the drug formulary, with the approval of the agency the division shall establish the amount to be reimbursed for the product based upon the price information provided by the manufacturer. The determination as to whether a product should be included in the drug formulary is based on the product's efficiency, cost, medical necessity, and safety. Any rebate returns, as a result of the provisions of this section regarding prescription drugs, shall be deposited in the general revenue fund.

(b) In the event any manufacturer of a prescription insulin drug included in §33-53-1 of this code certifies that the listed price of the prescription insulin drug is less than or equal to the list price which was publicly available for the same prescription insulin drug on July 1, 2006, the ~~Purchasing Division of the Department of Administration~~ purchasing division may negotiate an agreement on behalf of the Public Employees Insurance Agency, the schools of medicine of the state colleges and universities, the department of vocational rehabilitation and the Department of Health and Human Resources, to purchase the prescription insulin drug from the manufacturer at or below its July 1, 2006 list price, without negotiating, including or demanding any rebate. If a prescription insulin drug price is less than or equal to that drug's certified list price as of July 1, 2006, the division is hereby prohibited from negotiating any agreement for a rebate of a negotiated percentage of the total cost to be paid to the manufacturer or distributor of the specific prescription insulin drug; and the Public Employees Insurance Agency, the schools of medicine of the state colleges and universities, the department of vocational rehabilitation and the Department of Health and Human Resources are prohibited from any rebate from the manufacturer or distributor of the drug.

38 (c) It is expressly recognized that no other entity may interfere with the discretion and
39 judgment given to the single state agency that administers the state's Medicaid program.
40 Therefore, the Department of Health and Human Resources is authorized to negotiate rebates as
41 provided for this section.

## 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 surgical insurance plan or plans, a
2 group prescription drug insurance plan or plans, a group major medical insurance plan or plans
3 and a group life and accidental death insurance plan or plans for those employees herein made
4 eligible and establish and promulgate rules for the administration of these plans subject to the
5 limitations contained in this article. These plans shall include:
6 (1) Coverages and benefits for x-ray and laboratory services in connection with
7 mammograms when medically appropriate and consistent with current guidelines from the United
8 States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology,
9 whichever is medically appropriate and consistent with the current guidelines from either the
10 United States Preventive Services Task Force or The American College of Obstetricians and
11 Gynecologists; and a test for the human papilloma virus (HPV) when medically appropriate and

12 consistent with current guidelines from either the United States Preventive Services Task Force
13 or the American College of Obstetricians and Gynecologists, when performed for cancer
14 screening or diagnostic services on a woman age 18 or over;
15 (2) Annual checkups for prostate cancer in men age 50 and over;
16 (3) Annual screening for kidney disease as determined to be medically necessary by a
17 physician using any combination of blood pressure testing, urine albumin or urine protein testing,
18 and serum creatinine testing as recommended by the National Kidney Foundation;
19 (4) For plans that include maternity benefits, coverage for inpatient care in a duly licensed
20 healthcare facility for a mother and her newly born infant for the length of time which the attending
21 physician considers medically necessary for the mother or her newly born child. No plan may
22 deny payment for a mother or her newborn child prior to 48 hours following a vaginal delivery or
23 prior to 96 hours following a caesarean section delivery if the attending physician considers
24 discharge medically inappropriate;
25 (5) For plans which provide coverages for post-delivery care to a mother and her newly
26 born child in the home, coverage for inpatient care following childbirth as provided in §5-16-7(a)(4)
27 of this code if inpatient care is determined to be medically necessary by the attending physician.
28 These plans may include, among other things, medicines, medical equipment, prosthetic
29 appliances, and any other inpatient and outpatient services and expenses considered appropriate
30 and desirable by the agency; and
31 (6) Coverage for treatment of serious mental illness:
32 (A) The coverage does not include custodial care, residential care, or schooling. For
33 purposes of this section, “serious mental illness” means an illness included in the American
34 Psychiatric Association’s diagnostic and statistical manual of mental disorders, as periodically
35 revised, under the diagnostic categories or subclassifications of: (i) Schizophrenia and other
36 psychotic disorders; (ii) bipolar disorders; (iii) depressive disorders; (iv) substance-related
37 disorders with the exception of caffeine-related disorders and nicotine-related disorders; (v)

38 anxiety disorders; and (vi) anorexia and bulimia. With regard to a covered individual who has not
39 yet attained the age of 19 years, “serious mental illness” also includes attention deficit
40 hyperactivity disorder, separation anxiety disorder, and conduct disorder.

41 (B) Notwithstanding any other provision in this section to the contrary, if the agency
42 demonstrates that its total costs for the treatment of mental illness for any plan exceeds two
43 percent of the total costs for such plan in any experience period, then the agency may apply
44 whatever additional cost-containment measures may be necessary in order to maintain costs
45 below two percent of the total costs for the plan for the next experience period. These measures
46 may include, but are not limited to, limitations on inpatient and outpatient benefits.

47 (C) The agency shall not discriminate between medical-surgical benefits and mental
48 health benefits in the administration of its plan. With regard to both medical-surgical and mental
49 health benefits, it may make determinations of medical necessity and appropriateness and it may
50 use recognized healthcare quality and cost management tools including, but not limited to,
51 limitations on inpatient and outpatient benefits, utilization review, implementation of cost-
52 containment measures, preauthorization for certain treatments, setting coverage levels, setting
53 maximum number of visits within certain time periods, using capitated benefit arrangements,
54 using fee-for-service arrangements, using third-party administrators, using provider networks, and
55 using patient cost-sharing in the form of copayments, deductibles, and coinsurance.

56 (7) Coverage for general anesthesia for dental procedures and associated outpatient
57 hospital or ambulatory facility charges provided by appropriately licensed healthcare individuals
58 in conjunction with dental care if the covered person is:

59 (A) Seven years of age or younger or is developmentally disabled and is an individual for
60 whom a successful result cannot be expected from dental care provided under local anesthesia
61 because of a physical, intellectual, or other medically compromising condition of the individual
62 and for whom a superior result can be expected from dental care provided under general
63 anesthesia.

64 (B) A child who is 12 years of age or younger with documented phobias or with
65 documented mental illness and with dental needs of such magnitude that treatment should not be
66 delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of
67 teeth, or other increased oral or dental morbidity and for whom a successful result cannot be
68 expected from dental care provided under local anesthesia because of such condition and for
69 whom a superior result can be expected from dental care provided under general anesthesia.
70 (8) (A) Any plan issued or renewed on or after January 1, 2012, shall include coverage for
71 diagnosis, evaluation, and treatment of autism spectrum disorder in individuals ages 18 months
72 to 18 years. To be eligible for coverage and benefits under this subdivision, the individual must
73 be diagnosed with autism spectrum disorder at age eight or younger. Such plan shall provide
74 coverage for treatments that are medically necessary and ordered or prescribed by a licensed
75 physician or licensed psychologist and in accordance with a treatment plan developed from a
76 comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism
77 spectrum disorder.
78 (B) The coverage shall include, but not be limited to, applied behavior analysis which shall
79 be provided or supervised by a certified behavior analyst. The annual maximum benefit for applied
80 behavior analysis required by this subdivision shall be in an amount not to exceed $30,000 per
81 individual for three consecutive years from the date treatment commences. At the conclusion of
82 the third year, coverage for applied behavior analysis required by this subdivision shall be in an
83 amount not to exceed $2,000 per month, until the individual reaches 18 years of age, as long as
84 the treatment is medically necessary and in accordance with a treatment plan developed by a
85 certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the
86 individual. This subdivision does not limit, replace or affect any obligation to provide services to
87 an individual under the Individuals with Disabilities Education Act, 20 U. S. C. §1400 *et seq.*, as
88 amended from time to time or other publicly funded programs. Nothing in this subdivision requires
89 reimbursement for services provided by public school personnel.

90 (C) The certified behavior analyst shall file progress reports with the agency semiannually.
91 In order for treatment to continue, the agency must receive objective evidence or a clinically
92 supportable statement of expectation that:
93 (i) The individual's condition is improving in response to treatment;
94 (ii) A maximum improvement is yet to be attained; and
95 (iii) There is an expectation that the anticipated improvement is attainable in a reasonable
96 and generally predictable period of time.
97 (D) On or before January 1 each year, the agency shall file an annual report with the Joint
98 Committee on Government and Finance describing its implementation of the coverage provided
99 pursuant to this subdivision. The report shall include, but not be limited to, the number of
100 individuals in the plan utilizing the coverage required by this subdivision, the fiscal and
101 administrative impact of the implementation and any recommendations the agency may have as
102 to changes in law or policy related to the coverage provided under this subdivision. In addition,
103 the agency shall provide such other information as required by the Joint Committee on
104 Government and Finance as it may request.
105 (E) For purposes of this subdivision, the term:
106 (i) "Applied behavior analysis" means the design, implementation and evaluation of
107 environmental modifications using behavioral stimuli and consequences in order to produce
108 socially significant improvement in human behavior and includes the use of direct observation,
109 measurement, and functional analysis of the relationship between environment and behavior.
110 (ii) "Autism spectrum disorder" means any pervasive developmental disorder including
111 autistic disorder, Asperger's Syndrome, Rett Syndrome, childhood disintegrative disorder, or
112 Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and
113 Statistical Manual of Mental Disorders of the American Psychiatric Association.
114 (iii) "Certified behavior analyst" means an individual who is certified by the Behavior
115 Analyst Certification Board or certified by a similar nationally recognized organization.

116 (iv) "Objective evidence" means standardized patient assessment instruments, outcome
117 measurements tools, or measurable assessments of functional outcome. Use of objective
118 measures at the beginning of treatment, during, and after treatment is recommended to quantify
119 progress and support justifications for continued treatment. The tools are not required but their
120 use will enhance the justification for continued treatment.

121 (F) To the extent that the application of this subdivision for autism spectrum disorder
122 causes an increase of at least one percent of actual total costs of coverage for the plan year, the
123 agency may apply additional cost containment measures.

124 (G) To the extent that the provisions of this subdivision require benefits that exceed the
125 essential health benefits specified under section 1302(b) of the Patient Protection and Affordable
126 Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified
127 essential health benefits shall not be required of insurance plans offered by the Public Employees
128 Insurance Agency.

129 (9) For plans that include maternity benefits, coverage for the same maternity benefits for
130 all individuals participating in or receiving coverage under plans that are issued or renewed on or
131 after January 1, 2014: *Provided*, That to the extent that the provisions of this subdivision require
132 benefits that exceed the essential health benefits specified under section 1302(b) of the Patient
133 Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that
134 exceed the specified essential health benefits shall not be required of a health benefit plan when
135 the plan is offered in this state.

136 (10) (A) A policy, plan, or contract that is issued or renewed on or after January 1, 2019,
137 and that is subject to this section, shall provide coverage, through the age of 20, for amino acid-
138 based formula for the treatment of severe protein-allergic conditions or impaired absorption of
139 nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the
140 gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder

141 by a physician licensed to practice in this state pursuant to either §30-3-1 *et seq.,* or §30-14-1 *et*
142 *seq.* of this code:
143 (i) Immunoglobulin E and Non-immunoglobulin E-medicated allergies to multiple food
144 proteins;
145 (ii) Severe food protein-induced enterocolitis syndrome;
146 (iii) Eosinophilic disorders as evidenced by the results of a biopsy; and
147 (iv) Impaired absorption of nutrients caused by disorders affecting the absorptive surface,
148 function, length, and motility of the gastrointestinal tract (short bowel).
149 (B) The coverage required by §5-16-7(a)(10)(A) of this code shall include medical foods
150 for home use for which a physician has issued a prescription and has declared them to be
151 medically necessary, regardless of methodology of delivery.
152 (C) For purposes of this subdivision, "medically necessary foods" or "medical foods" shall
153 mean prescription amino acid-based elemental formulas obtained through a pharmacy: *Provided*,
154 That these foods are specifically designated and manufactured for the treatment of severe allergic
155 conditions or short bowel.
156 (D) The provisions of this subdivision shall not apply to persons with an intolerance for
157 lactose or soy.
158 (11) A policy, plan, or contract that is issued or renewed on or after July 1, 2020 shall
159 provide coverage for prescription insulin drugs pursuant to this section.
160 (A) For the purposes of this subdivision, "prescription insulin drug" means a prescription
161 drug that contains insulin, and is used to treat diabetes, and ~~a drug containing insulin and is used~~
162 ~~to control blood glucose level to treat diabetes,~~ includes at least one type of insulin in all of the
163 following categories:
164 (1) Rapid-acting;
165 (2) Short-acting;
166 (3) Intermediate-acting;

167 (4) Long-acting;

168 (5) Pre-mixed insulin products;

169 (6) Pre-mixed insulin/GLP-1 RA products;

170 (7) Concentrated human regular insulin.

171 (B) Cost sharing for a 30-day supply of a covered prescription insulin drug shall not exceed
172 $25 for a 30-day supply of a covered prescription insulin drug, used to fill the covered person's
173 prescription needs.

174 (C) Nothing in this section prevents the agency from reducing a covered person's cost
175 sharing by an amount greater than the amount specified in this subsection.

176 (D) No contract between the agency or its pharmacy benefits manager and a pharmacy
177 or its contracting agent shall contain a provision (i) authorizing the agency's pharmacy benefits
178 manager or the pharmacy to charge, (ii) requiring the pharmacy to collect, or (iii) requiring a
179 covered person to make a cost-sharing payment for a covered prescription insulin drug in an
180 amount that exceeds the amount of the cost-sharing payment for the covered prescription insulin
181 drug established by the agency as provided in §5-16-7(a)(11)(B) of this code.

182 (E) The agency shall provide coverage for the following equipment and supplies for the
183 treatment or management of diabetes for both insulin dependent and noninsulin dependent
184 persons with diabetes and those with gestational diabetes: Blood glucose monitors, monitor
185 supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for
186 controlling blood sugar and orthotics.

187 (F) The agency shall provide coverage for diabetes self-management education to ensure
188 that persons with diabetes are educated as to the proper self-management and treatment of their
189 diabetes, including information on proper diets. Coverage for self-management education and
190 education relating to diet shall be provided by a health care practitioner who has been
191 appropriately trained as provided in §33-53-1(k) of this code.

192 ~~(i) Visits medically necessary upon the diagnosis of diabetes;~~

193 ~~(ii) Visits under circumstances where a health care practitioner identifies or diagnoses a~~
194 ~~significant change in the patient's symptoms or conditions that necessitates changes in a patient's~~
195 ~~self-management; and~~
196 ~~(iii) Where a new medication or therapeutic process relating to the person's treatment or~~
197 ~~management of diabetes has been identified as medically necessary by a health care practitioner:~~
198 ~~*Provided*, That coverage for reeducation or refresher education shall be limited to $100 annually.~~
199 (G) The education may be provided by a health care practitioner as part of an office visit
200 for diabetes diagnosis or treatment, or by a licensed pharmacist for instructing and monitoring a
201 patient regarding the proper use of covered equipment, supplies and medications, or by a certified
202 diabetes educator, or registered dietitian.
203 (b) The agency shall, with full authorization, make available to each eligible employee, at
204 full cost to the employee, the opportunity to purchase optional group life and accidental death
205 insurance as established under the rules of the agency. In addition, each employee is entitled to
206 have his or her spouse and dependents, as defined by the rules of the agency, included in the
207 optional coverage, at full cost to the employee, for each eligible dependent.
208 (c) The finance board may cause to be separately rated for claims experience purposes:
209 (1) All employees of the State of West Virginia;
210 (2) All teaching and professional employees of state public institutions of higher education
211 and county boards of education;
212 (3) All nonteaching employees of the Higher Education Policy Commission, West Virginia
213 Council for Community and Technical College Education and county boards of education; or
214 (4) Any other categorization which would ensure the stability of the overall program.
215 (d) The agency shall maintain the medical and prescription drug coverage for Medicare-
216 eligible retirees by providing coverage through one of the existing plans or by enrolling the
217 Medicare-eligible retired employees into a Medicare-specific plan, including, but not limited to, the
218 Medicare/Advantage Prescription Drug Plan. If a Medicare-specific plan is no longer available or

219 advantageous for the agency and the retirees, the retirees remain eligible for coverage through

220 the agency.

NOTE: The purpose of this bill is to cap costs for insulin and provide certain coverage mandates.

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