WEST VIRGINIA LEGISLATURE

2022 REGULAR SESSION

Introduced

Senate Bill 607

BY SENATORS SYPOLT, PLYMALE, TAKUBO, AND

MARONEY

[Introduced February 09, 2022; referred

to the Committee on Finance]

A BILL to amend and reenact §5-16-8 of the Code of West Virginia, 1931, as amended, relating to the West Virginia Public Employees Insurance Act; conditions of insurance program; and requiring that provider reimbursement schedules shall be no lower than the reimbursement provided for the same services under Medicare.

Be it enacted by the Legislature of West Virginia:

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

§5-16-8. Conditions of insurance program.

The insurance plans provided for in this article shall be designed by the Public Employees Insurance Agency:

(1) To provide a reasonable relationship between the hospital, surgical, medical and prescription drug benefits to be included and the expected reasonable and customary hospital, surgical, medical and prescription drug expenses as established by the director to be incurred by the affected employee, his or her spouse and his or her dependents. The establishment of reasonable and customary expenses by the Public Employees Insurance Agency pursuant to the preceding sentence is not subject to the state administrative procedures act in chapter twenty-nine-a of this code;

(2) To include reasonable controls which may include deductible and coinsurance provisions applicable to some or all of the benefits, and shall include other provisions, including, but not limited to, copayments, preadmission certification, case management programs and preferred provider arrangements;

(3) To prevent unnecessary utilization of the various hospital, surgical, medical and prescription drug services available;

(4) To provide reasonable assurance of stability in future years for the plans;

(5) To provide major medical insurance for the employees covered under this article;

(6) To provide certain group life and accidental death insurance for the employees covered under this article;

(7) To include provisions for the coordination of benefits payable by the terms of the plans with the benefits to which the employee, or his or her spouse or his or her dependents may be entitled by the provisions of any other group hospital, surgical, medical, major medical, or prescription drug insurance or any combination thereof;

(8) To provide a cash incentive plan for employees, spouses and dependents to increase utilization of, and to encourage the use of, lower cost alternative health care facilities, health care providers and generic drugs. The plan shall be reviewed annually by the director and the advisory board;

(9) To provide “wellness” programs and activities which will include, but not be limited to, benefit plan incentives to discourage tobacco, alcohol and chemical abuse and an educational program to encourage proper diet and exercise. In establishing “wellness” programs, the division of vocational rehabilitation shall cooperate with the Public Employees Insurance Agency in establishing statewide wellness programs. The director of the Public Employees Insurance Agency shall contract with county boards of education for the use of facilities, equipment or any service related to that purpose. Boards of education may charge only the cost of janitorial service and increased utilities for the use of the gymnasium and related equipment. The cost of the exercise program shall be paid by county boards of education, the Public Employees Insurance Agency, or participating employees, their spouses or dependents. All exercise programs shall be made available to all employees, their spouses or dependents and shall not be limited to employees of county boards of education;

(10) To provide a program, to be administered by the director, for a patient audit plan with reimbursement up to a maximum of $1,000 annually, to employees for discovery of health care provider or hospital overcharges when the affected employee brings the overcharge to the attention of the plan. The hospital or health care provider shall certify to the director that it has provided, prior to or simultaneously with the submission of the statement of charges for payments, an itemized statement of the charges to the employee participant for which payment is requested

of the plan;

(11) To require that all employers give written notice to each covered employee prior to institution of any changes in benefits to employees, and to include appropriate penalty for any employer not providing the required information to any employee; ~~and~~

(12) To require that provider reimbursement schedules shall be no lower than the reimbursement provided for the same services under Medicare; and

~~(12)~~(13)(a) To provide coverage for emergency services under offered plans. For the purposes of this subsection, “emergency services” means services provided in or by a hospital emergency facility, an ambulance providing related services under the provisions of article four-c, chapter sixteen of this code or the private office of a dentist to evaluate and treat a medical condition manifesting itself by the sudden, and at the time, unexpected onset of symptoms that require immediate medical attention and for which failure to provide medical attention would result in serious impairment to bodily function, serious dysfunction to any bodily organ or part, or would place the person's health in jeopardy.

(b) From July 1, 1998, plans shall provide coverage for emergency services, including any prehospital services, to the extent necessary to screen and stabilize the covered person. The plans shall reimburse, less any applicable copayments, deductibles, or coinsurance, for emergency services rendered and related to the condition for which the covered person presented. Prior authorization of coverage shall not be required for the screening services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Prior authorization of coverage shall not be required for stabilization if an emergency medical condition exists. In the event that prior authorization was obtained, the authorization may not be retracted after the services have been provided except when the authorization was based on a material misrepresentation about the medical condition by the provider of the services or the insured person. The provider of the emergency services and the plan representative shall make a good faith effort to communicate with each other in a timely fashion to expedite postevaluation

or poststabilization services. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(c) For purposes of this subdivision:

(A) “Emergency services” means those services required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care;

(B) “Prudent layperson” means a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether an emergency medical condition exists for which emergency treatment should be sought;

(C) “Emergency medical condition for the prudent layperson” means one that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the person could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health, or, with respect to a pregnant woman, the health of the unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part;

(D) “Stabilize” means with respect to an emergency medical condition, to provide medical treatment of the condition necessary to assure, with reasonable medical probability that no medical deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility: *Provided,* That this provision may not be construed to prohibit, limit or otherwise delay the transportation required for a higher level of care than that possible at the treating facility;

(E) “Medical screening examination” means an appropriate examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists; and

(F) “Emergency medical condition” means a condition that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or

with respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of any bodily part or organ.

NOTE: The purpose of this bill is to require that provider reimbursement schedules under West Virginia Public Employees Insurance be no lower than the reimbursement provided for the same services under Medicare.

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