

**H. B. 2747**

(By Delegates Perdue, Hatfield, Marshall, Michael,  
Moore, Rodighiero, and Border)

[Introduced February 23, 2009; referred to the  
Committee on Health and Human Resources then Government Organization.]



A BILL to amend and reenact §5-16-7 of the Code of West Virginia, 1931, as amended; and to amend said code by adding thereto a new section, designated §33-3-14e, all relating to creating a temporary health information technology reinvestment fee for health insurers, providing definitions, establishing penalties for noncompliance, providing rule-making authority and establishing an effective date.

*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 said code be amended by adding thereto a new section, designated §33-3-14e, all to read as follows:

**CHAPTER 5. GENERAL POWERS 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 actuarially that its total anticipated costs for the treatment of 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 agency 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.

(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.

(e) The agency shall comply with the provisions of section fourteen-e, article three,

chapter thirty-three relating to the Health Care Information Technology Reinvestment Fee.

**CHAPTER 33. INSURANCE.**

**ARTICLE 3. LICENSING, FEES AND TAXATION.**

**§33-3-14e. Health Care Information Technology Reinvestment Fee.**

(a) The Legislature finds the following:

(1) Improving the capability to access and exchange electronic health information is a key component of the health care reform efforts in West Virginia.

(2) The access and exchange of electronic health information improves the quality of care and the efficiency of health practitioners.

(3) The financing model of the existing health care system results in most of the financial benefits of the use of health information technology not being realized by the primary care practitioners who have to invest in and use the electronic medical record but by those who pay for health care services.

(b) As used in this section:

(1) "Commission" means the Insurance Commission.

(2) "Commissioner" means the commissioner of the Insurance Commission.

(3) "Health insurance" means any group or individual health care benefit policy, contract, or other health benefit plan offered, issued, renewed, or administered by any health insurer, including any health care benefit plan offered, issued, or renewed by any health insurance company, any nonprofit hospital and medical service corporation, or any managed care organization as defined in chapter 33 of this code. The term does include the Public Employees Insurance Agency. The term does not include Medicaid, State

Children's Health Insurance Program, or any other state health care assistance program financed, in whole or in part, through a federal program, until authorized by the federal program. The term does not include policies issued for specified disease, accident, injury, hospital indemnity, dental care, long term care, disability income, or other limited benefit health insurance policies.

(4) "Health insurer" means an entity licensed by the commissioner to transact accident and sickness in this state, service corporations licensed pursuant to article twenty-four of this chapter or health maintenance organizations licensed pursuant to article twenty-six-a of this chapter, and "health TPA" means a TPA registered in accordance with the provisions of article forty-six of this chapter that handles health claims for any entity other than a health insurer.

(5) "WVHIN" is the West Virginia Health Information Network created in article twenty-nine-g of this chapter.

(c) The fee shall be established in the following manner:

(1) Quarterly, beginning October 1, 2009, each health insurer shall pay a fee into the West Virginia Health Information Network Account established in section four, article twenty-nine-g, chapter sixteen. The health insurer may choose either of the following fee options: (A) 0.199 of one percent of all health care claims paid by the health insurer for its West Virginia members in the previous fiscal quarter, or

(2) An annual fee payable quarterly, to be calculated on or before August 1, 2009 and on or before August 1 of each succeeding year by the Insurance Commission or by an agent retained by the commission, in consultation with the Governor's Office of Health

System Improvement, based on the proportion which the health insurer's total annual health care claims for the most recent four quarters of data available to the commission bears to the total health care claims for all health insurers for the most recent four quarters of data available to the commission, multiplied by the total fee revenue which would be raised if all health insurers chose the fee option established in subdivision (1) of this subsection. Such fee shall be subject to an annual recalculation by the Insurance Commission, or an agent retained by the commission, with any surplus or shortfall in the amount collected adjudicated in the following fiscal quarter and bearing no interest or penalty to any party.

(d) It is the intent of the Legislature that all health insurers shall contribute equitably to the West Virginia Health Information Network Account established in section four, article twenty-nine-g, chapter four.

(e) The West Virginia Health Information Network may adopt such legislative rules and issue such orders as are necessary to carry out the purposes of this section.

(f) If any health insurer fails to pay the fee established in subsection (a) of this section within forty-five days after notice from the WVHIN, the Director of WVHIN, or his or her designee, shall notify the Insurance Commission, and the Director of the Governor's Office of Health System Improvement of the failure to pay. In addition to any other remedy or sanction provided for by law, if the commissioner finds, after notice and an opportunity to be heard, that the health insurer has violated this section or any legislative rule or order adopted or issued pursuant to this section, the commissioner may take any one or more of the following actions:

(1) Assess an administrative penalty on the health insurer of not more than \$1,000 for each violation and not more than \$10,000 for each willful violation;

(2) Order the health insurer to cease and desist in further violations; or

(3) Order the health insurer to remediate the violation, including the payment of fees in arrears and payment of interest on fees in arrears at the rate of twelve percent per annum.

(g) No later than June 30, 2011, the Director of WVHIN and the Director of the Governor's Office of Health System Improvement, or his or her designee, shall assess the adequacy of funding and make recommendations to the Legislature and the Governor concerning the appropriateness of the duration of the health care information technology reinvestment fee.

(h) This section shall be effective from July 1, 2009 through June 30, 2012.

NOTE: The purpose of this bill is to create a temporary reinvestment fee for health insurers, third party administrators and others to assist in funding health information technology in the state.

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

This bill is an interim bill from Select Committee D on Health. Strike-throughs indicate language that would be stricken from the present law, and underscoring indicates new language that would be added.