COMMITTEE SUBSTITUTE

FOR

Senate Bill No. 407

(By Senators Minard, Foster, Kessler
(Acting President) and Stollings)

[Originating in the Committee on Health and Human Resources;
reported February 16, 2011.]

A BILL to amend and reenact §33-15-2 of the Code of West Virginia, 1931, as amended; to amend said code by adding thereto a new article, designated §33-15F-1, §33-15F-2, §33-15F-3, §33-15F-4, §33-15F-5, §33-15F-6, §33-15F-7, §33-15F-8, §33-15F-9, §33-15F-10, §33-15F-11 and §33-15F-12; and to amend and reenact §33-16-1a of said code, all relating to federal health insurance reforms; incorporating the federal mandates of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010; defining terms; granting rule-making authority; preventing health care insurers from imposing additional charges for

certain preventive benefits; preventing health care insurers from imposing annual and lifetime benefits limits and providing exceptions; establishing provisions for provider networks; prohibiting health care insurers from imposing preexisting condition exclusions for persons under the age of nineteen; permitting eligibility for dependent children to the age of twenty-six with conditions; and establishing review and appeal rights.

Be it enacted by the Legislature of West Virginia:

That §33-15-2 of the Code of West Virginia, 1931, as amended, be amended and reenacted; that said code be amended by adding thereto a new article, designated §33-15F-1, §33-15F-2, §33-15F-3, §33-15F-4, §33-15F-5, §33-15F-6, §33-15F-7, §33-15F-8, §33-15F-9, §33-15F-10, §33-15F-11 and §33-15F-12; and that §33-16-1a of said code be amended and reenacted, all to read as follows:

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-2. Scope and format of policy.

No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

(a) The entire money and other considerations therefor are expressed therein; and

(b) The time at which the insurance takes effect and terminates is expressed therein; and

(c) It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall ~~not exceed nineteen~~ not be less than twenty-five years and any other person dependent upon the policyholder. For purposes of this subsection, if a policy provides coverage for dependent children, "children" shall include any naturally born child, adopted child, stepchild, child of whom the policyholder is the legal guardian, and a child for whom the policyholder is under court order to provide healthcare benefits; and

(d) The policy is guaranteed to be renewable at the option of the insured except as provided in section two-d of this article; and

(e) The style, arrangement and over-all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and

of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lowercase unspaced alphabet length not less than one hundred and twenty-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions), the policy shall clearly indicate on the first page the conditions of renewability; and

(f) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in sections four and five of this article, are printed, at the insurer's option, either included with the benefit provisions to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and Reductions": *Provided,* That if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; and

(g) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first part thereof; and

(h) It contains no provision purporting to make any portion of the charter, rules, Constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner; and

(i) Effective the July 1, 1997, the insurer offers and accepts for enrollment pursuant to section two-b of this article every eligible individual who applies for coverage within sixty-three days after termination of the individual's prior creditable coverage.

ARTICLE 15F. REFORMS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.

§33-15F-1. Purpose.

Although the regulation of private health insurance markets has historically been the province of the states, the Patient Protection and Affordable Care Act of 2010, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, includes new federal mandates affecting health insurers offering health benefit plans that may also be enforced by states with sufficient statutory authority to do so. In order to preserve,

to the greatest extent possible, state regulatory control consistent with these new federal laws. This article incorporates many of the substantive reforms into the state insurance code and provides the Insurance Commissioner with sufficient flexibility to meet additional changes to federal laws through rulemaking and other regulatory measures.

§33-15F-2. Definitions of terms in this article.

For the purposes of this article:

(a) "Adverse determination" means:

(1) A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;

(2) The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization

review organization of a covered person's eligibility to participate in the health carrier's health benefit plan; or

(3) Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit.

(4) Adverse determination includes a rescission of coverage determination.

(b) "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

(c) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

(d) "Certification" means a determination by a health carrier or its designee utilization review organization that a request for a benefit under the health carrier's health benefit plan has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

(e) "Child" includes any naturally born child, adopted child, stepchild, child of whom the policyholder is the legal

guardian, and a child for whom the policyholder is under court order to provide healthcare benefits.

(f) "Closed plan" means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan.

(g) "Commissioner" means the West Virginia Insurance Commissioner.

(h) "Concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting.

(i) "Covered benefits or benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(j) "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

(k) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

(l) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient

severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(m) "Emergency services" means, with respect to an emergency medical condition:

(1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(2) Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

(n) "Essential health benefits" has the meaning under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations and include:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Laboratory services;

(5) Maternity and newborn care;

(6) Mental health and substance abuse disorder services, including behavioral health treatment;

(7) Pediatric services, including oral and vision care;

(8) Prescription drugs;

(9) Preventive and wellness services and chronic disease management; and

(10) Rehabilitative and habilitative services and devices.

(o) "Exchange" means the West Virginia Health Benefits Exchange established pursuant to section four, article sixteen-g of this chapter.

(p) "Facility" means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

(q) "Federal Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health

Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under those Acts.

(r) "Final adverse determination" means an adverse determination that has been upheld by the health carrier at the completion of the internal appeals process or with respect to which the internal appeals process has been deemed exhausted in accordance with.

(s) "Grievance" means a written complaint or oral complaint if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding:

(1) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(2) Claims payment, handling or reimbursement for health care services; or

(3) Matters pertaining to the contractual relationship between a covered person and a health carrier.

(t) "Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(u) "Group health plan" means an employee welfare benefit plan as defined in Section 3(1) of the Employee

Retirement Income Security Act of 1974 (ERISA) to the extent that the plan provides medical care, and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(v) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(1) "Health benefit plan" does not include:

(A) Coverage only for accident, or disability income insurance, or any combination thereof;

(B) Coverage issued as a supplement to liability insurance;

(C) Liability insurance, including general liability insurance and automobile liability insurance;

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for on-site medical clinics; or

(H) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under

which benefits for health care services are secondary or incidental to other insurance benefits.

(2) "Health benefit plan" also does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(A) Limited scope dental or vision benefits;

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(C) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(3) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(A) Coverage only for a specified disease or illness; or

(B) Hospital indemnity or other fixed indemnity insurance.

(4) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(A) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(B) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(C) Similar supplemental coverage provided to coverage under a group health plan.

(w) "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

(x) "Health care provider" or "provider" means a health care professional or a facility.

(y) "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

(z) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the

jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

(aa) "Health maintenance organization" means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for the covered person's responsibility for copayments, coinsurance or deductibles.

(bb)"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance: *Provided*, That a health carrier offering health insurance coverage in connection with a group health plan shall not be deemed to be a health carrier offering individual health insurance coverage solely because the carrier offers a conversion policy.

(cc) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(dd) "Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

(ee) "Medical care" means amounts paid for:

(1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in paragraph(1); and

(3) Insurance covering medical care referred to in subdivision (1) and (2) of this subsection.

(ff) "Network" means the group of participating providers providing services to a managed care plan.

(gg) "Open enrollment" means, with respect to individual health insurance coverage, the period of time during which any individual has the opportunity to apply for coverage under a health benefit plan offered by a health carrier and shall be accepted for coverage under the plan without regard to a preexisting condition.

(hh) "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial

incentives, for covered persons to use participating providers under the terms of the managed care plan.

(ii) "Participant" has the meaning given for such term under Section 3(7) of ERISA.

(jj) "Participating health care professional" means a health care professional who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

(kk) "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

(ll) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

(mm) "Preexisting condition exclusion" means a limitation or exclusion of benefits, including a denial of coverage,

based on the fact that the condition was present before the effective date of coverage, or if the coverage is denied, the date of denial, under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was recommended or received before the effective date of coverage; such term also includes any limitation or exclusion of benefits, including a denial of coverage, applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if the coverage is denied, the date of denial, under the health benefit plan, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

(nn) "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

(oo) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the

criteria for certification for sale within a health benefits exchange.

(pp) "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage has only a prospective effect or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(qq) "Retrospective review" means any review of a request for a benefit that is not a prospective review request. Retrospective review does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

(rr) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the initial proposed health care service.

(ss) "Secretary" means the Secretary of the United State Department of Health and Human Services.

(tt) "SHOP Exchange" means the Small Business Health Operations Program established under article sixteen-G of this chapter.

(uu) (1) "Small employer" means an employer that employed an average of not more than fifty employees during the preceding calendar year.

(2) For purposes of this subsection:

(A) All persons treated as a single employer under Section 414(b), (c), (m) or (o) of the Internal Revenue Code of 1986 shall be treated as a single employer;

(B) An employer and any predecessor employer shall be treated as a single employer;

(C) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

(D) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and

(E) An employer that makes enrollment in qualified health plans available to its employees through the Small Business

Health Options Program, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this article as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

(vv) "Subscriber" means, in the case of individual health insurance contract, the person in whose name the contract is issued.

(ww) (1) "Urgent care request" means a request for a health care service or course of treatment with respect to which the time periods for making a nonurgent care request determination:

(A) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(B) In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

(2) (A) Except as provided in paragraph (B) of this subdivision, in determining whether a request is be treated as an

urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(B) Any request that a physician with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of Paragraph (1) shall be treated as an urgent care request.

(xx) "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

(yy) "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing utilization review for its own health benefit plans.

§33-15F-3. Applicability; interpretive standards; effect of invalid federal laws.

(a) Except as provided herein in emergency and legislative rules promulgated pursuant to this article or in other

regulatory guidance, the provisions of this article shall be effective with respect to health benefit plans in force on or after the effective date of the enactment of this section during the 2011 regular session of the Legislature.

(b) The provisions of this article shall be construed in accordance with relevant federal statutes, regulations and other sources of guidance issued by federal agencies. To the extent the applicability of a provision of the federal act is limited to non-grandfathered plans, as that term is defined in the federal act and regulations promulgated thereunder, the corresponding provisions of this article shall be similarly limited to such plans.

(c) The provisions of this article control whenever there is a conflict with a provision elsewhere in this code. In the event any portion of the federal act or of any regulation or other guidance is legislatively or judicially invalidated and rendered of no effect in this state, the corresponding provisions of such act, regulation or guidance as set forth in this article or in emergency or legislative rules shall likewise be considered to be of no further effect, and the Insurance Commissioner shall immediately issue an informational letter setting forth his or her legal opinion as to the effect of

such legislative or judicial action on the regulation of the health insurance market in this state and on the continuing validity of the provisions of this article and any rules promulgated pursuant to this article.

§33-15F-4. Rule-making authority.

The commissioner has authority to adopt emergency rules and to propose rules for legislative approval, pursuant to chapter twenty-nine-a of this code, to effectuate or implement this article as well as any provision of the federal act and related federal laws related to healthcare reforms, and such rulemaking authority is not limited to the subjects expressly addressed by this article.

§33-15F-5. Preventive benefits.

A group health plan and a health insurance issuer offering group or individual health benefit plans shall, at a minimum, provide coverage for and shall not impose any cost sharing requirements for the following, as certified by the commissioner and set forth in emergency or legislative rules:

(1) Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

(2) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of

the Centers for Disease Control and Prevention with respect to the individual involved; and

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

(4) With respect to women, such additional preventive care and screenings not described in subdivision (1) of this subsection as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

§33-15F-6. Annual and lifetime limits.

A group health plan and a health insurance issuer offering group or individual health benefit plan shall not establish lifetime or annual limits on the dollar value of essential benefits for any participant or beneficiary. A group health plan or health benefit plan may place annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted. The commissioner may establish by emergency or legislative rule restricted annual limits on the dollar value of benefits for any participant or beneficiary

with respect to the scope of benefits that are essential health benefits for plan years beginning prior to January 1, 2014.

§33-15F-7. Rescissions.

Section seven, article six of this chapter applies to all health benefit plans.

§33-15F-8. Medical loss ratios; reporting not required.

The reporting requirements contained in section one-b, article fifteen and subsection (g), section five, article sixteen-d of this chapter are not applicable to any carrier that is subject to similar reporting with respect to greater loss ratios mandated by the federal act and regulations promulgated thereunder.

§33-15F-9. Provider network provisions.

(a) If a group health plan, or a health insurance issuer offering group or individual health benefit plan, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) In the case of a person who has a child who is a participant, beneficiary, or enrollee, if the plan or issuer requires or

provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate an allopathic or osteopathic physician who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer. That nothing in subsections (a) or (b) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(c) If a group health plan, or a health insurance issuer offering group or individual health benefit plans, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services without the need for any prior authorization determination, and such services shall be provided: (1) Regardless of whether the health care provider furnishing such services is a participating provider with respect to such services; and (2) subject to the same cost-sharing provisions and other terms of coverage regardless of whether the provider is in the network.

(d) A group health plan, or health insurance issuer offering group or individual health benefit plans may not require

authorization or referral by the plan, issuer, or any person, including a primary care provider, in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology: *Provided,* That such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to any treatment plan approved by the plan or issuer.

§33-15F-10. Prohibition on preexisting condition exclusions for individuals under the age of nineteen.

(a) A health carrier shall not limit or exclude coverage under an individual health benefit plan for an individual under the age of nineteen by imposing a preexisting condition exclusion on that individual. Health carriers offering health benefit plans may hold one or more open enrollment periods during which children may be enrolled on a guaranteed issue basis. An individual under the age of nineteen may not be denied coverage on the basis of a preexisting condition outside an open enrollment period if he or she has lost coverage due to a qualifying event such as employer termina-

tion of a contribution for dependent coverage or other situations defined in rule.

(b) Each health carrier offering health benefit plans shall provide prior prominent public notice on its Internet website and prior written notice to each of its policyholders annually at least ninety days before any open enrollment period of the open enrollment rights for individuals under the age of nineteen and provide information as to how an individual eligible for this open enrollment right may apply for coverage with the carrier during an open enrollment period.

(c) Except as otherwise provided in this section or in rules adopted hereunder, this section applies to grandfathered plan coverage for group health benefit plans and does not apply to grandfathered plan coverage for individual health benefit plans.

§33-15F-11. Review and appeal rights.

(a) The commissioner shall adopt emergency and legislative rules to set forth minimum requirements for utilization review and management, grievance and external review processes to be adopted by health benefit plans.

(b) Every health benefit plan shall have in effect provisions ensuring for appropriate grievance and external review procedures to apply to adverse determinations.

§33-15F-12. Eligibility for dependent coverage to age twenty-six.

(a) A health carrier offering health benefit plans that makes available dependent coverage of children shall make that coverage available for children until attainment of twenty-six years of age, regardless of the child's marital status, residency, or lack of dependency on the primary subscriber or plan participant.

(b) Any child who is not covered because he or she had lost coverage or had been denied coverage on the basis of age shall be afforded written notice of eligibility to enroll and at least thirty days to apply for such coverage. Notice may be provided to an employee on behalf of the employee's child and, in the individual market, to the primary subscriber on behalf of the primary subscriber's child.

(c) For plan years beginning before January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered plan and makes available dependent coverage of children may exclude an adult child who has not attained twenty-six years of age from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health benefit plan.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-1a. Definitions.

As used in this article:

(a) "Bona fide association" means an association which has been actively in existence for at least five years; has been formed and maintained in good faith for purposes other than obtaining insurance; does not condition membership in the association on any health status-related factor relating to an individual; makes accident and sickness insurance offered through the association available to all members regardless of any health status-related factor relating to members or individuals eligible for coverage through a member; does not make accident and sickness insurance coverage offered through the association available other than in connection with a member of the association; and meets any additional requirements as may be set forth in this chapter or by rule.

(b) "Child" means any of the following:

(1) A naturally born child, adopted child or stepchild of the eligible employee;

(2) A child for whom the eligible employee is the legal guardian; or

(3) A child for whom the eligible employee is under court order to provide health coverage.

~~(b)~~ (c) "Commissioner" means the ~~Commissioner of Insurance~~ West Virginia Insurance Commissioner.

~~(c)~~ (d) "Creditable coverage" means, with respect to an individual, coverage of the individual after June 30, 1996, under any of the following, other than coverage consisting solely of excepted benefits:

(1) A group health plan;

(2) A health benefit plan;

(3) Medicare Part A or Part B, 42 U. S. C. § 1395 et seq.; Medicaid, 42 U. S. C. § 1396a et seq. (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act); Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), 10 U. S. C., Chapter 55; and a medical care program of the Indian Health Service or of a tribal organization;

(4) A health benefits risk pool sponsored by any state of the United States or by the District of Columbia; a health plan offered under 5 U. S. C., chapter 89; a public health plan as defined in regulations promulgated by the federal secretary of health and human services; or a health benefit plan as defined in the Peace Corps Act, 22 U. S. C. § 2504(e).

~~(d)~~ (e) "Dependent" means an eligible employee's spouse or any dependent unmarried child ~~or stepchild~~ under the age of

twenty-five ~~if that child or stepchild meets the definition of a "qualifying child" or a "qualifying relative" in section 152 of the Internal Revenue Code~~.

~~(e)~~ (f) "Eligible employee" means an employee, including an individual who either works or resides in this state, who meets all requirements for enrollment in a health benefit plan.

~~(f)~~ (g) "Excepted benefits" means:

(1) Any policy of liability insurance or contract supplemental thereto; coverage only for accident or disability income insurance or any combination thereof; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; workers' compensation insurance; or other similar insurance under which benefits for medical care are secondary or incidental to other insurance benefits; or

(2) If offered separately, a policy providing benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof, dental or vision benefits or other similar, limited benefits; or

(3) If offered as independent, noncoordinated benefits under separate policies or certificates, specified disease or

illness coverage, hospital indemnity or other fixed indemnity insurance, or coverage, such as Medicare supplement insurance, supplemental to a group health plan; or

(4) A policy of accident and sickness insurance covering a period of less than one year.

~~(g)~~ (h) "Group health plan" means an employee welfare benefit plan, including a church plan or a governmental plan, all as defined in section three of the Employee Retirement Income Security Act of 1974, 29 U. S. C. § 1003, to the extent that the plan provides medical care.

~~(h)~~ (i) "Health benefit plan" means benefits consisting of medical care provided directly, through insurance or reimbursement, or indirectly, including items and services paid for as medical care, under any hospital or medical expense incurred policy or certificate; hospital, medical or health service corporation contract; health maintenance organization contract; or plan provided by a multiple-employer trust or a multiple-employer welfare arrangement. "Health benefit plan" does not include excepted benefits.

~~(i)~~ (j) "Health insurer" means an entity licensed by the commissioner to transact accident and sickness in this state and subject to this chapter. "Health insurer" does not include a group health plan.

~~(j)~~ (k) "Health status-related factor" means an individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) or disability.

~~(k)~~ (l) "Medical care" means amounts paid for, or paid for insurance covering, the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, including amounts paid for transportation primarily for and essential to such care.

~~*(l)*~~ (m) "Mental health benefits" means benefits with respect to mental health services, as defined under the terms of a group health plan or a health benefit plan offered in connection with the group health plan.

~~(m)~~ (n) "Network plan" means a health benefit plan under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the health insurer.

~~(n)~~ (o) "Preexisting condition exclusion" means, with respect to a health benefit plan, a limitation or exclusion of

benefits relating to a condition based on the fact that the condition was present before the enrollment date for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before the enrollment date.

(NOTE: The purpose of this bill is to incorporate the federal Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 into the insurance code. The bill defines terms and grants rule-making authority. The bill prevents health care insurers from imposing additional charges for certain preventive benefits and prevents health care insurers from imposing annual and lifetime benefits limits and provides exceptions. The bill also establishes provisions for provider networks. The bill prohibits health insurers from imposing preexisting condition exclusions for persons under nineteen. The bill further permits eligibility for dependent children to the age of twenty-six with conditions. The bill also establishes review and appeal rights.

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

§33-15F-1, §33-15F-2, §33-15F-3, §33-15F-4, §33-15F-5, §33-15F-6, §33-15F-7, §33-15F-8, §33-15F-9, §33-15F-10, §33-15F-11 and §33-15F-12 are new; therefore, strike-throughs and underscoring have been omitted.)