WEST VIRGINIA LEGISLATURE

2020 REGULAR SESSION

Introduced

Senate Bill 284

BY SENATORS CARMICHAEL (MR. PRESIDENT), CLINE,

MAYNARD, AND MARONEY

[Introduced January 10, 2020; referred

to the Committee on Banking and Insurance; and then

to the Committee on Health and Human Resources]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §33-53-1, §33-53-2, §33-53-3, §33-53-4, §33-53-5, §33-53-6, §33-53-7, §33-53-8, §33-53-9, §33-53-10, §33-53-11, and §33-53-12, all relating to West Virginia Health Care Continuity Act; including provisions for the creation of a State Commission on Health Care Continuity, when the act becomes effective, the establishment of the West Virginia Patient Protection Pool risk-sharing program, and the involvement of the Joint Committee on Government and Finance; providing limitations on preexisting condition exclusions for health benefit plans; requiring rulemaking; requiring fairness in cost sharing and ratemaking; and including a conflict of laws provision.

Be it enacted by the Legislature of West Virginia:

ARTICLE 53. WEST VIRGINIA HEALTHCARE CONTINUITY ACT.

§33-53-1. Short title.

This article may be cited and known as the West Virginia Healthcare Continuity Act.

§33-53-2. Definitions and applicability.

(a) For purposes of this article:

"Commissioner" means the Commissioner of Insurance.

"Program" means the West Virginia Patient Protection Pool established pursuant to this article.

"Health insurance policy" means any individual insurance policy, group insurance policy, or other health benefit plan subject to the requirements of §33-15-1 *et seq.* and §33-16-1 *et seq.* of this code.

"Preexisting condition exclusion" has the same meaning as it does in §33-16-1a of this code.

"Affiliation period" means a period that begins on a policyholder or dependent's enrollment date, runs concurrently with any waiting period under the health insurance policy, must expire before coverage is effective, and during which the policy provider need not provide benefits for

medical care and may not charge any premium to the policyholder or dependent.

(b) The provisions of this article only become effective if the commissioner determines, in his or her sole discretion, that a court of competent jurisdiction has ruled that all or a significant portion of the Patient Protection and Affordable Care Act, P.L. 111-148, is unconstitutional and the judgment of that court becomes final and definitive.

(c) Unless otherwise noted, the provisions of this article become effective 90 days after the commissioner publishes notice of the determination described in subsection (b) of this section in newspapers of general circulation throughout the state, as described in §59-3-1 of this code. However, the provisions of this article do not abridge or affect the provisions of insurance policies or contracts already in effect until the policies or contracts are renewed.

(d)(1) If the provisions of this article become effective, pursuant to subsection (c) of this section, before June 30th of any calendar year, then the requirements of this article apply to all health insurance policies, contracts, plans, or agreements, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after June 30th of that calendar year.

(2) If the provisions of this article become effective, pursuant to subsection (c) of this section, on or after June 30th of any calendar year, then the requirements of this article apply to all health insurance policies, contracts, plans, or agreements, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after June 30th of the next calendar year.

(e) If the commissioner determines, in his or her sole discretion, that the tax credit authorized in Section 1401 of the Patient Protection and Affordable Care Act of 2010, P. L. 111-148, as amended by the Healthcare and Education Reconciliation Act of 2010, P. L. 111-152, and codified in Section 16B of the Internal Revenue Code, has been held to be invalid by a court of competent jurisdiction, or is otherwise unenforceable at law, then:

(1) The State Commission on Healthcare Continuity shall be created, and shall have the objective of identifying state or federal policies to replicate the tax credit authorized in Section

1401 of the Patient Protection and Affordable Care Act of 2010, P. L. 111-148, as amended by the Healthcare and Education Reconciliation Act of 2010, P. L. 111-152, and codified in Section 16B of the Internal Revenue Code;

(2) The State Commission on Healthcare Continuity shall be chaired by the commissioner, and shall consist of the commissioner, the Secretary of the West Virginia Department of Revenue, and the Secretary of the West Virginia Department of Health and Human Resources;

(3) The commissioner shall transmit notice of the creation of the State Commission on Healthcare Continuity to the members described in subdivision (2) of this subsection;

(4) The members of the State Commission on Healthcare Continuity, or their designees, shall meet and adopt, by majority vote, recommendations of state or federal policies to effectuate the objective identified in subdivision (1) of this subsection;

(5) The State Commission on Healthcare Continuity, in consultation with the Attorney General, shall prepare a report outlining the recommendations described in subdivision (4) of this subsection; and

(6) The State Commission on Healthcare Continuity shall, within 60 days of the transmittal of notice described in subdivision (3) of this subsection, transmit the report described in subdivision (5) of this subsection to the Governor, the President of the West Virginia Senate, and the Speaker of the West Virginia House of Delegates.

§33-53-3. Establishment of the West Virginia Patient Protection Pool.

(a) The commissioner shall establish the West Virginia Patient Protection Pool, which is a risk-sharing program to provide payment to health insurance issuers for claims for healthcare services provided to eligible individuals with expected high healthcare costs for the purpose of lowering premiums for health insurance coverage offered in the individual market.

(b) In establishing the program, the commissioner shall do all of the following:

(1) Examine West Virginia's historical experience with the West Virginia Health Insurance Plan high risk pool, established in § 33-48-1 *et seq.* of this code;

(2) Consult with healthcare consumers, health insurance issuers, and other interested stakeholders; and

(3) Take into consideration high-cost health conditions and other health trends that generate a high cost.

§33-53-4. Operation of the program.

(a) The commissioner shall establish the program with a framework and operation consistent with other state best practices.

(b) The program may be administered by either the commissioner or an independent nonprofit organization.

§33-53-5. Actuarial analysis.

In establishing the program, the commissioner shall commission an actuarial analysis to do all of the following:

(1) Inform the development and parameters of the program;

(2) Evaluate how funds that may currently be utilized to pay the Health Insurance Provider Fee (HIPF) or may be recovered pursuant to litigation related to the HIPF may be used to contribute to the funding of the guaranteed benefits pool; and

(3) Estimate the necessary funding required to reach the premium reduction goals of the program, taking into consideration all of the sources provided in this section.

§33-53-6. Program parameters.

In establishing the program, the commissioner shall provide for all of the following:

(1) The criteria for individuals to be eligible for participation in the program;

(2) The development and use of health status statements with respect to eligible individuals.

(3) The standards for qualification, including, but not limited to, all of the following:

(A) The identification of health conditions that automatically qualify individuals as eligible individuals at the time of application for health insurance coverage; and

(B) A process pursuant to which health insurance issuers may voluntarily qualify individuals who do not automatically qualify as eligible individuals at the time of application for coverage.

(4) The percentage of the premiums paid to health insurance issuers for health insurance coverage by eligible individuals that shall be collected and deposited to the credit and available for the use of the program.

(5) The threshold dollar amount of claims for eligible individuals after which the program will provide payments to health insurance issuers and the proportion of the claims above the threshold dollar amount that the program will pay.

§33-53-7. Approval by the Joint Committee on Government and Finance.

(a) The commissioner shall submit the actuarial analysis required by §33-53-5 of this code to the Joint Committee on Government and Finance on or before the later of:

(1) November 1 of the year this article becomes effective; or

(2) The 124th day after this article becomes effective.

(b) The commissioner shall submit a report containing a detailed description of the proposed program to the Joint Committee on Government and Finance within 121 days after reporting the actuarial analysis required by §33-53-5 of this code to the Joint Committee on Government and Finance.

(c) The Joint Committee on Government and Finance shall meet to review and approve the actuarial analysis, the details of the program as determined by the commissioner, and any required funding. The committee may also take any other action with respect to the program deemed necessary by the committee.

§33-53-8. Required plan provisions.

(a) The commissioner shall promulgate by rule minimum policy coverage standards applicable to all health insurance policies subject to this article. In addition to any other requirements provided by law, such standards shall require any policy regulated under this article

to provide as benefits to all enrollees coverage for:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn care;

(5) Mental health and substance use disorder services, including behavioral health treatment;

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

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

(10) Pediatric services including oral and vision care.

(b) Any policy subject to this article may not establish lifetime or annual limits on the dollar value of benefits described in subsection (f) of this section for any covered person.

(c) Any policy subject to this article that offers coverage for a dependent child shall offer dependent coverage, at the option of the policyholder, until the dependent child reaches the age of 26.

§33-53-9. Limitations on preexisting condition exclusions for health benefit plans.

(a) For plan years beginning after June 30 of the calendar year in which this article becomes effective, a health insurance policy may not impose a preexisting condition exclusion.

(b) A policy issuer may:

(1) Restrict enrollment in a health insurance plan to open enrollment and special enrollment periods in accordance with other provisions of this chapter;

(2) Impose an affiliation period on any health insurance policy that is not provided through the individual market: *Provided*, That said affiliation period may not exceed 90 days; and

(3) Use other alternatives approved by the commissioner to address adverse selection.

§33-53-10. Fairness in cost sharing and ratemaking.

(a) As used in this section:

"Cost sharing" means any copayment, coinsurance, or deductible required by or on behalf of a covered person in order to receive a specific health care item or service covered by a health insurance policy.

"Drug" is defined in §30-5-4(19) of this code.

"Person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, nonprofit corporation, unincorporated organization, or government or governmental subdivision or agency.

"Pharmacy benefits manager" is defined in §33-51-3 of this code.

"Premium adjustment percentage" for any calendar year means the percentage by which the average per capita premium for health insurance policies in this state in the previous calendar year, as determined by the commissioner not later than October 1 of the preceding calendar year, exceeds the average per capita premium for 2019.

(b) A health insurance policy issuer may not require cost sharing in an amount greater than the cost sharing limit amount.

(1) For plan years beginning in calendar year 2020, the cost sharing limit amount shall be $8,150 for self-only coverage and $16,300 for other than self-only coverage.

(2) For plan years beginning in a calendar year after 2020, the cost sharing limit shall be equal to the dollar amount applicable to the previous calendar year, increased by the product of that amount and the premium adjustment percentage as determined by the commissioner for the calendar year.

(c) When calculating an insured's contribution to any applicable cost sharing requirement, including, but not limited to, the annual limitation on cost sharing subject to subsection (b) of this section:

(1) An insurer shall include any cost sharing amounts paid by the insured or on behalf of

an enrollee by another person; and

(2) A pharmacy benefits manager shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person.

(d) Premium rates charged by any health insurance policy subject to this article shall be reasonable in relation to the benefits available under the policy, as determined by the commissioner.

(e) A health insurance policy issued pursuant to this article may charge different premium rates from each person covered by that policy, but the premium rates may not vary by a rate exceeding five to one. In addition, premium rates may vary only in relation to the following:

(1) Whether the policy covers an individual or a family;

(2) Rating area, as established pursuant to subsection (g) of this section;

(3) Age, except that the rate may not vary by more than three to one for adults; and

(4) Tobacco use, except that the rate may not vary by more than one and one-half to one.

(f) With respect to family coverage under an individual or group health insurance policy, the rating variations permitted under this section shall be applied based on the portion of the premium that is attributable to each family member covered under the policy.

(g) The commissioner shall promulgate rules to establish:

(1) One or more geographic rating areas within the state and the permissible age bands within which premium rates may vary; and

(2) Minimum standards for ratemaking and cost sharing, in accordance with accepted actuarial principles and practices.

§33-53-11. Rule-making authority.

(a) The commissioner may promulgate rules:

(1) Establishing the program, pursuant to §33-53-3 through §33-53-7 of this code;

(2) Establishing essential minimum plan provisions, pursuant to §33-53-8 of this code;

(3) Establishing acceptable methods of addressing adverse selection in enrollment,

pursuant to §33-53-9 of this code;

(4) Establishing standards for ratemaking and cost sharing, and defining geographic rating areas, pursuant to §33-53-10 of this code; and

(5) Addressing any other standard or practice necessary to effectuate the purposes of this article.

(b) The commissioner shall establish these rules pursuant to §29A-1-1 *et seq.* of this code.

§33-53-12. Conflict of laws.

(a) Health insurance plans that are subject to the requirements and provisions of this article remain subject to every other requirement and provision of this code that is not inconsistent with this article.

(b) If a provision of this article conflicts with another provision of this code, then the provision of this article controls, unless the application of this article would result in a reduction of coverage.

NOTE: The purpose of this bill is to ensure healthcare coverage plans meet certain minimum standards, remain affordable, and are not denied on the basis of preexisting conditions.

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