

# **WEST VIRGINIA LEGISLATURE**

## **2020 REGULAR SESSION**

### **Committee Substitute**

**for**

### **Committee Substitute**

**for**

## **Senate Bill 284**

SENATORS CARMICHAEL (MR. PRESIDENT), CLINE,

MAYNARD, AND MARONEY, *original sponsors*

[Originating in the Committee on Health and Human

Resources; reported on February 19, 2020]



1 A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section,  
2 designated §33-15-4u; to amend said code by adding thereto a new section, designated  
3 §33-16-3ff; to amend said code by adding thereto a new section, designated §33-24-7u;  
4 to amend said code by adding thereto a new section, designated §33-25-8r; to amend  
5 said code by adding thereto a new section, designated §33-25A-8u; to amend said code  
6 by adding thereto a new article, designated §33-53-1, §33-53-2, §33-53-3, §33-53-4, §33-  
7 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  
8 relating to establishing the West Virginia Health Care Continuity Act; making the act  
9 applicable to existing code; including provisions for the creation of a State Commission on  
10 Health Care Continuity when the act becomes effective; establishing the West Virginia  
11 Patient Protection Pool Risk-Sharing Program and review by the Joint Committee on  
12 Government and Finance; providing limitations on preexisting condition exclusions for  
13 health benefit plans; requiring rulemaking; requiring fairness in cost sharing and  
14 ratemaking; and including a conflict of laws provision.

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

## **ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE**

### **§33-15-4u. Incorporation of the Health Care Continuity Act.**

1 The provisions of the Health Care Continuity Act codified at §33-53-1 et seq. of this code  
2 are made applicable to the provisions of this article.

## **ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.**

### **§33-16-3ff. Incorporation of the Health Care Continuity Act.**

1 The provisions of the Health Care Continuity Act codified at §33-53-1 et seq. of this code  
2 are made applicable to the provisions of this article.

**ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS, AND HEALTH SERVICE CORPORATIONS.**

**§33-24-7u. Incorporation of the Health Care Continuity Act.**

1        The provisions of the Health Care Continuity Act codified at §33-53-1 et seq. of this code  
2        are made applicable to the provisions of this article.

**ARTICLE 25. HEALTH CARE CORPORATIONS.**

**§33-25-8r. Incorporation of the Health Care Continuity Act.**

1        The provisions of the Health Care Continuity Act codified at §33-53-1 et seq. of this code  
2        are made applicable to the provisions of this article.

**ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.**

**§33-25A-8u. Incorporation of the Health Care Continuity Act.**

1        The provisions of the Health Care Continuity Act codified at §33-53-1 et seq. of this code  
2        are made applicable to the provisions of this article.

**ARTICLE 53. WEST VIRGINIA HEALTH CARE CONTINUITY ACT.**

**§33-53-1. Short title.**

1        This article may be cited and known as the West Virginia Health Care Continuity Act.

**§33-53-2. Definitions and applicability.**

1        (a) For purposes of this article:

2        “Commissioner” means the Commissioner of Insurance.

3        “Program” means the West Virginia Patient Protection Program established pursuant to  
4        this article.

5        “Health insurance policy” means any individual insurance policy, group insurance policy,  
6        or other health benefit plan subject to the requirements of §33-15-1 et seq., §33-16-1 et seq., §33-

7 24-1 et seq., §33-25-1 et seq., or §33-25A-1 et seq. of this code, but does not mean any policy  
8 offering only “excepted benefits” as that term is defined in §33-16-1a(f) of this code.

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

11 “Affiliation period” means a period that begins on a policyholder or dependent’s enrollment  
12 date, runs concurrently with any waiting period under the health insurance policy, must expire  
13 before coverage is effective, and during which the policy provider need not provide benefits for  
14 medical care and may not charge any premium to the policyholder or dependent.

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

19 (c) Unless otherwise noted, the provisions of this article shall become effective 90 days  
20 after the commissioner publishes notice of the determination described in subsection (b) of this  
21 section in newspapers of general circulation throughout the state, as described in §59-3-1 of this  
22 code.

23 (d) The requirements of this article apply to all health insurance policies that are delivered,  
24 executed, issued, amended, adjusted, or renewed in this state on or after the 180th day after the  
25 commissioner finalizes the implementing rules described in §33-53-11 of this code. However:

26 (1) A rule promulgated pursuant to §33-53-11 may specify an applicability date that is  
27 earlier than 180 days after the date the rule is finalized, in which case the date specified in the  
28 rule controls; and

29 (2) The requirements of this article shall not abridge or affect the provisions of health  
30 insurance policies already in effect at the time these requirements become applicable until such  
31 policies are renewed.

32 (e) If the commissioner determines, in his or her sole discretion, that the tax credit  
33 authorized in Section 1401 of the Patient Protection and Affordable Care Act of 2010, P. L. 111-  
34 148, as amended by the Health Care and Education Reconciliation Act of 2010, P. L. 111-152,  
35 and codified in Section 16B of the Internal Revenue Code, has been held to be invalid by a court  
36 of competent jurisdiction, or is otherwise unenforceable at law, then:

37 (1) The State Commission on Health Care Continuity shall be created, and shall have the  
38 objective of identifying state or federal policies to replicate the tax credit authorized in Section  
39 1401 of the Patient Protection and Affordable Care Act of 2010, P. L. 111-148, as amended by  
40 the Health Care and Education Reconciliation Act of 2010, P. L. 111-152, and codified in Section  
41 16B of the Internal Revenue Code;

42 (2) The State Commission on Health Care Continuity shall be chaired by the commissioner  
43 and shall consist of the commissioner, the Cabinet Secretary of the West Virginia Department of  
44 Revenue, and the Cabinet Secretary of the West Virginia Department of Health and Human  
45 Resources;

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

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

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

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

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

1           (a) The commissioner shall establish the West Virginia Patient Protection Program, which  
2 is a reinsurance program to provide payment to health insurance issuers for claims for health care  
3 services provided to eligible individuals with expected high health care costs for the purpose of  
4 lowering premiums for health insurance coverage offered in the individual market.

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

6           (1) Examine West Virginia's historical experience with the West Virginia Health Insurance  
7 Plan high-risk pool, established in §33-48-1, et seq. of this code, reinsurance programs in other  
8 states, and other information sources that he or she considers instructive:

9           (2) Consult with health care consumers, health insurance issuers, and other interested  
10 stakeholders; and

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

**§33-53-4. Operation of the program.**

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

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

**§33-53-5. Actuarial analysis.**

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

3           (a) Inform the development and parameters of the program;

4           (b) Evaluate how funds that may currently be utilized to pay the health insurance provider  
5 fee (HIPF) or may be recovered pursuant to litigation related to the HIPF may be used to  
6 contribute to the funding of the program; and

7           (c) Estimate the necessary funding required to reach the premium reduction goals of the  
8 program and identify resources available for the program.

**§33-53-6. Program parameters.**

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

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

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

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

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

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

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

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

**§33-53-7. Implementation of the program and review by the Joint Committee on**  
**Government and Finance.**

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

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

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

5           (b) The commissioner shall propose rules for legislative approval implementing the  
6 program pursuant to §29A-3-1, et seq. of this code. The Legislature finds that an emergency  
7 exists and, therefore, the commissioner shall promulgate emergency rules implementing the  
8 program pursuant to §29A-3-1 et seq. of this code within 121 days after reporting the actuarial  
9 analysis required by §33-53-5 of this code to the Joint Committee on Government and Finance.

10           (c) The commissioner shall submit detailed reports of the program's operation to the Joint  
11 Committee on Government and Finance annually by November 1.

**§33-53-8. Required policy provisions.**

1           (a) The commissioner shall promulgate by rule minimum policy coverage standards  
2 applicable to all health insurance policies subject to this article. In addition to any other  
3 requirements provided by law, such standards shall require any policy regulated under this article  
4 to provide as benefits to all enrollees coverage for:

5           (1) Ambulatory patient services;

6           (2) Emergency services;

7           (3) Hospitalization;

8           (4) Maternity and newborn care;

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

11           (6) Prescription drugs;

12           (7) Rehabilitative and habilitative services and devices;

13           (8) Laboratory services;

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

15           (10) Pediatric services, including oral and vision care.

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

18 (c) A health insurance policy subject to this article that offers coverage for any children or  
19 stepchildren of a policyholder shall continue to offer such coverage, at the option of the  
20 policyholder, until the unmarried child or stepchild reaches the age of 26.

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

1 (a) A health insurance policy issuer may not impose a preexisting condition exclusion and  
2 may not deny enrollment to any individual on the basis of a preexisting condition.

3 (b) A policy issuer may:

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

6 (2) Impose an affiliation period on any health insurance policy that is not provided through  
7 the individual market: *Provided*, That said affiliation period shall not exceed 90 days and shall not  
8 apply to emergency services; and

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

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

1 (a) As used in this section:

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

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

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

9 “Pharmacy benefits manager” is defined in §33-51-3 of this code.

10 “Premium adjustment percentage” for any calendar year means the percentage by which  
11 the average per capita premium for health insurance policies in this state in the previous calendar

12 year, as determined by the commissioner not later than October 1 of such preceding calendar  
13 year, exceeds such average per capita premium for 2019.

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

16 (1) For plan years beginning in calendar year 2020, the cost-sharing limit amount shall be  
17 \$8,150 for self-only coverage and \$16,300 for other than self-only coverage.

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

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

25 (1) An insurer shall include any cost-sharing amounts paid by the insured or on behalf of  
26 an enrollee by another person; and

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

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

32 (e) A health insurance policy subject to this article may charge different premium rates  
33 from each person covered by that policy, but said premium rates may vary only in relation to the  
34 following:

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

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

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

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

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

43 (g) The commissioner shall promulgate rules to establish:

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

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

**§33-53-11. Rule-making authority.**

1 (a) The commissioner shall promulgate rules:

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

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

4 (3) Establishing acceptable methods of addressing adverse selection in enrollment,  
5 pursuant to §33-53-9 of this code;

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

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

10 (b) The commissioner shall propose rules for legislative approval in accordance with the  
11 provisions of §29A-3-1 et seq. of this code.

**§33-53-12. Conflict of laws.**

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

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