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WEST VIRGINIA LEGISLATURE

3rd Extraordinary Session, 2004

ENROLLED

SENATE BILL NO. 3005

(By Senators Tomblin, Mr. President, and Sprouse,)
By Request of the Executive)

PASSED November 16, 2004

In Effect from **Passage**

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Senate Bill No. 3005

(BY SENATORS TOMBLIN, MR. PRESIDENT, AND SPROUSE,
BY REQUEST OF THE EXECUTIVE)

[Passed November 16, 2004; in effect from passage.]

AN ACT to amend and reenact §33-48-2, §33-48-4, §33-48-6 and §33-48-7 of the code of West Virginia, 1931, as amended; and to amend said code by adding thereto a new section, designated §33-48-7a, all relating to the West Virginia health insurance plan; placing the plan within the office of the insurance commissioner; exempting the plan from certain state purchasing requirements; authorizing the hiring of an executive director and exempting such director from the classified service; changing eligibility criteria for the plan; limiting the eligibility of recipients of the West Virginia children's health insurance program; prohibiting balance billing of plan members by health care providers for covered services provided under the plan; authorizing the insurance commissioner to utilize department staff and resources in administering the plan; and creating a special revenue account known as the "West Virginia health insurance plan fund" for the purpose of receiving and expending moneys to be used in connection with the West Virginia health insurance plan.

Be it enacted by the Legislature of West Virginia:

That §33-48-2, §33-48-4, §33-48-6 and §33-48-7 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 §33-48-7a, all to read as follows:

ARTICLE 48. MODEL HEALTH PLAN FOR UNINSURABLE INDIVIDUALS ACT.

§33-48-2. Operation of the plan.

(a) There is hereby created within the department a body corporate and politic to be known as the West Virginia health insurance plan which shall be deemed to be an instrumentality of the state and a public corporation. The plan shall have perpetual existence and any change in the name or composition of the plan shall in no way impair the obligations of any contracts existing under this article.

(b) The plan shall operate subject to the supervision and control of the board. The board shall consist of the commissioner or his or her designated representative, who shall serve as an ex officio member of the board and shall be its chairperson, and six members appointed by the governor. At least two board members shall be individuals, or the parent, spouse or child of individuals, reasonably expected to qualify for coverage by the plan. At least two board members shall be representatives of insurers. At least one board member shall be a hospital administrator. A majority of the board shall be composed of individuals who are not representatives of insurers or health care providers.

(c) The initial board members shall be appointed as follows: One third of the members to serve a term of two years; one third of the members to serve a term of four years; and one third of the members to serve a term of six years. Subsequent board members shall serve for a term of three years. A board member's term shall continue until his or her successor is appointed.

(d) Vacancies in the board shall be filled by the governor. Board members may be removed by the governor for cause.

(e) Board members shall not be compensated in their capacity as board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties.

(f) The board shall submit to the commissioner a plan of operation for the plan and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the plan. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this article must be made available. If the board fails to submit a suitable plan of operation within one hundred eighty days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall adopt and promulgate such rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the commissioner or superseded by a plan of operation submitted by the board and approved by the commissioner.

(g) The plan of operation shall:

(1) Establish procedures for operation of the plan: *Provided*, That the plan shall be operated so as to qualify as an acceptable alternative mechanism under the federal Health Insurance Portability and Accountability Act and as an option to provide health insurance coverage for individuals eligible for the federal health care tax credit established by the federal Trade Adjustment Assistance Reform Act of 2002 (Section 35 of the Internal Revenue Code of 1986);

(2) Establish procedures for selecting an administrator in accordance with section six of this article;

(3) Establish procedures for the handling, accounting and auditing of assets, moneys and claims of the plan and the plan administrator;

(4) Develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment;

(5) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the board. The grievances shall be reported to the board after completion of the review. The board shall retain all written complaints regarding the plan for at least three years; and

(6) Provide for other matters as may be necessary and proper for the execution of the board's powers, duties and obligations under this article.

(h) The plan shall have the general powers and authority granted under the laws of this state to health insurers and, in addition thereto, the specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this article, including the authority, with the approval of the commissioner, to enter into contracts with similar plans of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions: *Provided*, That the provisions of article three, chapter five-a of this code relating to the division of purchasing of the department of administration do not apply to any contracts executed by or on behalf of the plan under this article;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the plan;

(3) Take such legal action as necessary:

(A) To avoid the payment of improper claims against the plan or the coverage provided by or through the plan;

(B) To recover any amounts erroneously or improperly paid by the plan;

(C) To recover any amounts paid by the plan as a result of mistake of fact or law; or

(D) To recover other amounts due the plan;

(4) Establish and modify, from time to time, as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the plan. Rates and rate schedules may be adjusted for appropriate factors such as age, sex and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices;

(5) Issue policies of insurance in accordance with the requirements of this article;

(6) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the plan, policy and other contract design and any other function within the authority of the pool;

(7) Borrow money to effect the purposes of the plan. Any notes or other evidence of indebtedness of the plan not in default shall be legal investments for insurers and may be carried as admitted assets;

(8) Establish rules, conditions and procedures for reinsuring risks of participating insurers desiring to issue plan coverages in their own name. Provision of reinsurance shall not subject the plan to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers;

(9) Employ and fix the compensation of employees, including an executive director of the plan. The executive director shall have overall management responsibility for the plan and is exempt from the classified service and not subject to the procedures and protections provided by articles six and six-a, chapter twenty-nine of this code;

(10) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public;

(11) Provide for reinsurance of risks incurred by the plan;

(12) Issue additional types of health insurance policies to provide optional coverages, including medicare supplemental insurance;

(13) Provide for and employ cost containment measures and requirements, including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review and individual case management for the purpose of making the benefit plan more cost effective;

(14) Design, utilize, contract or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations and other limited network provider arrangements: *Provided*, That all contracts with preferred provider organizations, health maintenance organizations, other network providers or other health care providers shall provide that plan participants are not personally liable for the cost of services covered by the plan other than applicable deductibles or copayments, including any balance claimed by the provider to be owed as being the difference between that provider's charge or charges and the amount payable by the plan; and

(15) Adopt bylaws, policies and procedures as may be necessary or convenient for the implementation of this article and the operation of the plan.

(i) The board shall make an annual report to the governor which shall also be filed with the Legislature. The report shall summarize the activities of the plan in the preceding calendar year, including the net written and earned premiums, plan enrollment, the expense of administration, and the paid and incurred losses.

(j) Study and recommend to the Legislature in January, two thousand six, alternative funding mechanisms for the continuation of the health plan for uninsurable individuals.

(k) Neither the board nor its employees shall be liable for any obligations of the plan. No member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this article unless such act or omission constitutes willful or wanton misconduct. The board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

§33-48-4. Eligibility.

(a) The following persons are eligible for plan coverage:

(1) Any individual who is and continues to be a resident of this state if evidence is provided of a notice of rejection or refusal to issue substantially similar insurance for health reasons by one insurer or of a refusal by an insurer to issue insurance except at a rate exceeding the plan rate, except that a rejection or refusal by an insurer offering only stop loss, excess of loss or reinsurance coverage shall not be sufficient evidence under this subdivision;

(2) Any individual who is legally domiciled in this state and is eligible for the credit for health insurance costs

under Section 35 of the Internal Revenue Code of 1986; and

(3) Any federally defined eligible individual who has not experienced a significant break in coverage and who is and continues to be a resident of this state.

(b) The board shall promulgate a list of medical or health conditions for which a person is eligible for plan coverage without applying for health insurance coverage pursuant to subdivision (1), subsection (a) of this section. Persons who can demonstrate the existence or history of any medical or health conditions on the list promulgated by the board are not required to prove the evidence specified in said subdivision. The list shall be effective on the first day of the operation of the plan and may be amended, from time to time, as may be appropriate.

(c) Each dependent of a person who is eligible for plan coverage is also eligible for plan coverage.

(d) A person is not eligible for coverage under the plan if:

(1) The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy or would be eligible to have coverage if the person elected to obtain it, except that:

(A) A person may maintain other coverage for the period of time the person is satisfying any preexisting condition waiting period under a plan policy; and

(B) A person may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the plan policy;

(2) The person is determined to be eligible for health care benefits under the state medicaid law or the West Virginia children's health insurance program;

(3) The person has previously terminated plan coverage unless twelve months have lapsed since such terminations, except that this subdivision does not apply with respect to an applicant who is a federally defined eligible individual or with respect to an applicant who has exhausted annual benefits under the West Virginia children's health insurance program;

(4) The plan has paid out one million dollars in benefits on behalf of the person;

(5) The person is an inmate or resident of a public institution, except that this subdivision does not apply with respect to an applicant who is a federally defined eligible individual; or

(6) The person's premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.

(e) Coverage shall cease:

(1) On the date a person is no longer a resident of this state;

(2) On the date a person requests coverage to end;

(3) Upon the death of the covered person;

(4) On the date state law requires cancellation of the policy; or

(5) At the option of the plan, thirty days after the plan makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.

(f) Except under the circumstance described in subsection (d) of this section, a person who ceases to meet the eligibility requirements of this section may be terminated

at the end of the policy period for which the necessary premiums have been paid.

§33-48-6. Plan administrator.

(a) The board shall select a plan administrator through a competitive bidding process to administer the plan. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(1) The plan administrator's proven ability to handle health insurance coverage to individuals;

(2) The efficiency and timeliness of the plan administrator's claim processing procedures;

(3) An estimate of total charges for administering the plan;

(4) The plan administrator's ability to apply effective cost containment programs and procedures and to administer the plan in a cost-efficient manner; and

(5) The financial condition and stability of the plan administrator.

(b) (1) The plan administrator shall serve for a period specified in the contract between the plan and the plan administrator subject to removal for cause and subject to any terms, conditions and limitations of the contract between the plan and the plan administrator.

(2) At least one year prior to the expiration of each period of service by a plan administrator, the board shall invite eligible entities, including the current plan administrator, to submit bids to serve as the plan administrator. Selection of the plan administrator for the succeeding period shall be made at least six months prior to the end of the current period.

(c) The plan administrator shall perform such functions relating to the plan as may be assigned to it, including:

(1) Determination of eligibility;

(2) Payment of claims;

(3) Establishment of a premium billing procedure for collection of premium from persons covered under the plan; and

(4) Other necessary functions to assure timely payment of benefits to covered persons under the plan.

(d) The plan administrator shall submit regular reports to the board regarding the operation of the plan. The frequency, content and form of the report shall be specified in the contract between the board and the plan administrator.

(e) Following the close of each calendar year, the plan administrator shall determine net written and earned premiums, the expense of administration and the paid and incurred losses for the year and report this information to the board and the commission on a form prescribed by the commissioner.

(f) Notwithstanding any other provision in this section to the contrary, the board may elect to designate the public employees insurance agency as the plan administrator. If so designated, the public employees insurance agency shall provide the services set forth in subsection (c) of this section and shall be subject to the reporting requirements of subsections (d) and (e) of this section. The plan shall, if the public employees insurance agency is designated by the board as the plan administrator, reimburse health care providers at the same health care reimbursement rates then in effect for the West Virginia public employees insurance agency and health care providers are subject to the same prohibition against balance billing of plan participants as set forth in section four, article twenty-nine-d, chapter sixteen of this code.

§33-48-7. Funding of the plan.

(a) *Premiums.* –

(1) The plan shall establish premium rates for plan coverage as provided in subdivision (2) of this subsection. Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the commissioner for approval prior to use.

(2) The plan, with the assistance of the commissioner, shall determine a standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for plan coverage shall not be less than one hundred twenty-five percent of rates established as applicable for individual standard risks. Subject to the limits provided in this subdivision, subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves and any other cost factors subject to the limitations described herein. In no event shall plan rates exceed one hundred fifty percent of rates applicable to individual standard risks.

(b) Notwithstanding the provisions of subsection (c), section eight, article twenty-nine-b, chapter sixteen of this code and not to be construed as in conflict therewith, the health care authority is authorized to increase the assessment obligation of hospitals in an amount not to exceed a maximum of twenty-five percent above the one tenth of one percent specified in said subsection and the entire assessment, including the additional assessment, shall be collected as specified in said subsection Upon receipt of the additional assessment, the health care authority shall transfer all proceeds generated from the additional assessment collected to the special revenue account established in section seven-a of this article.

(c) The plan is authorized to receive and expend any federal grant.

(d) With the consent of the board, the commissioner is authorized to utilize his or her administrative staff and resources in administering this article. The board shall reimburse the commissioner for all costs of administrative and actuarial services, supplies and other costs incurred by the commissioner in implementing the provisions of this article.

§33-48-7a. Special revenue account created.

(a) There is hereby created a special revenue account in the state treasury, designated the "West Virginia Health Insurance Plan Fund", which shall be an interest-bearing account and may be invested in the manner permitted by article six, chapter twelve of this code, with the interest income a proper credit to the fund, unless otherwise designated in law. The fund shall be administered by the commissioner, under the supervision and control of the board, and used to pay all proper costs incurred in implementing the provisions of this article, all administrative costs of the plan, all claims and all proper ongoing costs of the plan. Moneys deposited into this account are available for expenditure as the commissioner may direct in accordance with the provisions of this article.

(b) The following funds shall be paid into this account:

(1) All premium payments received from individuals insured by the plan;

(2) All other payments, gifts or income from any source; and

(3) Transfers from the health care authority of all proceeds generated from the additional assessment collected pursuant to subsection (b), section seven of this article at any time after the first day of July, two thousand four.

The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

Originated in the Senate.

In effect from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker House of Delegates

The within is approved this the 2nd

Day of December, 2004.

Governor

PRESENTED TO
THE GOVERNOR
DATE 11/19/04
TIME 4:20 pm