WEST VIRGINIA LEGISLATURE

2025 REGULAR SESSION

Introduced

House Bill 3233

By Delegate Young

[Introduced March 07, 2025; referred to the

Committee on Health and Human Resources then

Finance]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding a new article, designated §9-4F-1, §9-4F-2, §9-4F-3, §9-4F-4, §9-4F-5, §9-4F-6, §9-4F-7, §9-4F-8, and §9-4F-9, relating to creating the Insurance Buy-In Program; requiring the Department of Human Services to develop and administer the Insurance Buy-In Plan; setting eligibility criteria and coverage requirements; specifying role and duties of the Department of Human Services; establishing an advisory council to the Insurance Buy-In Program; defining terms; setting limitations of employers; requiring a full-cost option be available for individuals who do not meet financial qualifications; requiring rule-making; and mandating application for necessary federal options and innovation waivers to maximize federal funding of the Program.

Be it enacted by the Legislature of West Virginia:

ARTICLE 4F. INSURANCE BUY-IN PROGRAM.

§9-4F-1. Purpose.

The purpose of the Insurance Buy-In Program is to establish a new state option efficiently maximizing available federal funds to provide West Virginia residents with a choice of a high-quality, low-cost health insurance plan.

§9-4F-2. Definitions.

As used in this article:

"Copayment" means a fixed dollar amount that an Insurance Buy-in enrollee must pay directly to a health care provider or pharmacy for a service, visit or item;

"Deductible" means a fixed dollar amount that a person enrolled in the Insurance buy-in plan may be required to pay during a benefit period before the plan begins payment for covered benefits;

"Department" means the Department of Human Services;

"Health care coverage premium cost" means the premium charged for health care coverage that is available or currently provided to an individual;

"Health care provider" means any physical, mental or behavioral health provider, including a hospital, physician, clinic and other health facility;

"Insurance Buy-In Plan" or "plan" means a state-administered, health care coverage plan that leverages the Medicaid coverage structure;

"Managed care organization" means an organization licensed or authorized through an agreement among state entities to manage, coordinate and receive payment for the delivery of specified services to enrolled members;

"Medicaid" means the joint federal-state health coverage program pursuant to Title 19 or Title 21 of the federal Social Security Act, as amended, and the rules promulgated pursuant to that act;

"Medicare" means coverage under Part A or Part B of Title 18 of the federal Social Security Act, as amended, and the rules promulgated pursuant to that act;

"Premium" means the monthly amount that a plan enrollee must pay directly to the managed care organization offering the enrollee’s plan for consideration of the plan's coverage; and

"Resident" means a person establishing intent to permanently reside in West Virginia.

§9-4F-3. The plan.

(a) By January 1, 2026, the department shall establish an Insurance Buy-In Plan and shall offer the plan for purchase by a resident:

(1) Who is ineligible for the following:

(A) Medicaid; and

(B) Medicare; and

(2) Whose employer has not disenrolled or denied the resident enrollment in employer-sponsored health coverage on the basis that the resident would otherwise qualify for enrollment in Insurance buy-in coverage.

(b) The department shall establish benefits under the plan in accordance with federal and

state law to ensure that covered benefits include:

(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) Preventive and wellness services, including reproductive health and chronic disease management; and

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

(c) For services and benefits provided under this section, the department may pursue any available federal financial participation.

(d) The department shall coordinate the plans enrollment and eligibility to maximize the continuity of coverage between the plan, Medicaid and private health plans.

(e) Health care provider reimbursement rates shall be based on the Medicaid fee schedule. Contingent upon available funds, the department may increase reimbursement rates for health care providers, so long as these increases do not jeopardize the sustainability of Medicaid or the plan.

(f) The plan shall be established in compliance with nondiscrimination mandates set forth in the Constitution of West Virginia, the West Virginia Human Rights Act, and the federal Civil Rights Act of 1964 and shall be available to residents irrespective of age, race, gender, national origin, immigration status, disability or geographic location.

(g) The department shall establish an updated premium sliding scale for individuals under

200 percent of the federal poverty level who purchase the Medicaid Buy-in plan. The sliding scale shall prioritize individuals transitioning from Medicaid coverage.

§9-4F-4. Administration.

(a) The department shall develop a plan for administering the plan that prioritizes affordability for enrollees and provides opportunities to maximize federal dollars.

(b) The department shall:

(1) Establish an affordability scale for premiums and other cost-sharing fees, such as copayments and deductibles, based on household income. The department shall offer discounted premiums and cost-sharing fees in accordance with the affordability scale to residents eligible to enroll in the plan: *Provided,* That the financial assistance is, at a minimum, offered to residents with household incomes below 200 percent of the federal poverty level;

(2) Establish fair and reasonable premium rates that should be assessed to plan enrollees, after an actuarial analysis, to ensure maximum access to coverage. Premiums imposed may be set at a level sufficient to offset the costs of health benefits under the plan and related administrative costs; and

(c) The department may:

(1) Administer the plan through the managed care organizations under contract with the State to provide Medicaid services and benefits; and

(2) Set the medical loss ratio for insurers offering the plan consistent with the ratio applicable to Medicaid;

(d) The department shall:

(1) Establish a standardized benefit and cost sharing design for the plan; and

(2) Establish a method for procuring prescription drugs. This authority includes consulting or contracting with other entities or states for combined purchasing power; and

(3) Seek viable opportunities to reduce costs of the plan to consumers and the general fund: *Provided,* That these opportunities are consistent with the provisions of this article, do not

reduce eligibility or benefits for Medicaid enrollees and do not jeopardize federal financing for medical assistance.

§9-4F-5. Financing.

(a) The department shall apply for a Basic Health Plan Option under Section 1331 and/or a State Innovation Waiver under Section 1332 of the Patient Protection and Affordable Care Act. The department shall maximize all available federal dollars to fund the Insurance d Buy-In Program. Nothing in the waiver application may prohibit individuals and families from purchasing plans on the Marketplace.

(b) Individuals who do not qualify for federal financial assistance may purchase the plan at full cost.

§9-4F-8. Rule-making authority.

The Secretary of the Department of Human Services shall propose emergency rules in accordance with the provisions of §29A-3-15 to implement the provisions of this article. Thereafter, the secretary shall propose additional rules for legislative approval in accordance with the provisions of §29A-3-1 *et seq.* as may be needed to administer and maintain the Insurance Buy-In Program.

§9-4F-9. Limitation on employers.

An employer that offers employer-sponsored health coverage as of the effective date of this article may not disenroll or deny enrollment to a resident covered under the employer's employer-sponsored health coverage on the basis that the employer believes that the resident would qualify for plan coverage.

NOTE: The purpose of this bill is to create the Insurance Buy-In Program. The bill requires the Department of Human Services to develop and administer the Insurance Buy-In Plan. The bill creates the Health Care Affordability and Access Improvement Fund. The bill establishes an advisory council to the Program. The bill requires a study and reposts be made. The bill defines terms. The bill sets limitations of employers. The bill requires rule-making.

Strike-throughs indicate language that would be stricken from a heading or the present law,

and underscoring indicates new language that would be added.