WEST VIRGINIA LEGISLATURE

2025 REGULAR SESSION

Introduced

Senate Bill 832

By Senator Chapman

[Introduced March 20, 2025; referred to

the Committee on Finance]

A BILL to amend and reenact §33-15-4t, §33-16-3ee, §33-24-7t, §33-25-8q, and §33-25A-8t of the Code of West Virginia, 1931, as amended, relating to cost-sharing calculations; defining terms; requiring insurer to provide credit toward in-network cost sharing; prohibiting insurer from discriminating in the form of payment; and setting effective date.

Be it enacted by the Legislature of West Virginia:

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4t. Fairness in Cost-Sharing Calculation.

(a) As used in this section:

"Average allowed amount" means the average of all contractually agreed upon amounts paid by an insurer to a health care provider or other entity participating in the insurer's network. The average shall be calculated according to payments within a reasonable amount of time not to exceed one calendar year. The insurance commissioner may approve methodologies for calculating the average allowed amount that are based on any of the following: a specific covered person's insurer, all insurer plans offered in the state by a specific insurer, or a geographic area.

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

"Discounted cash price" means the price charged to individuals who pay cash (or cash equivalent) for an individual item or service or service package.

"Drug" means the same as the term is defined in §30-5-4 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" means the same as that term is defined in §33-51-3 of this code.

(b) 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 42 U.S.C. § 18022(c)

and 42 U.S.C. § 300gg-6(b):

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

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

(3) A covered person who elects to receive a covered health care service at a discounted cash price that is below the average allowed amount shall receive credit toward the covered person's in-network cost-sharing as specified in the covered person's insurer's plan, as if the health care service is provided by an in-network health care provider; and

(4) An insurer shall not discriminate in the form of payment for any covered in-network health care service solely on the basis that the covered person was referred for the health care by an out-of-network health care provider.

(c) The commissioner is authorized to propose rules for legislative approval in accordance with §29A-3-1 et seq. of this code to implement the provisions of this section.

(d) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2020. The amendments made to this article during the 2025 regular session of the Legislature are effective on January 1, 2026. This section applies to all policies, contracts, plans, or agreements, subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(e) If under federal law application of subsection (b) of this section would result in Health Savings Account ineligibility under Section 223 of the Internal Revenue Code, this requirement shall apply only for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code: Provided, That with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, the requirements of subsection (b) of this section shall apply regardless of whether the minimum deductible under

Section 223 of the Internal Revenue Code has been satisfied.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3ee. Fairness in Cost-Sharing Calculation.

(a) As used in this section:

"Average allowed amount" means the average of all contractually agreed upon amounts paid by an insurer to a health care provider or other entity participating in the insurer's network. The average shall be calculated according to payments within a reasonable amount of time not to exceed one calendar year. The insurance commissioner may approve methodologies for calculating the average allowed amount that are based on any of the following: a specific covered person's insurer, all insurer plans offered in the state by a specific insurer, or a geographic area.

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

"Discounted cash price" means the price charged to individuals who pay cash (or cash equivalent) for an individual item or service or service package.

"Drug" means the same as the term is defined in §30-5-4 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" means the same as that term is defined in §33-51-3 of this code.

(b) 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 42 U.S.C. § 18022(c) and 42 U.S.C. § 300gg-6(b):

(1) An insurer shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person; ~~and~~

(2) A pharmacy benefits manger shall include any cost sharing amounts paid by the

insured or on behalf of the insured by another person;

(3) A covered person who elects to receive a covered health care service at a discounted cash price that is below the average allowed amount shall receive credit toward the covered person's in-network cost-sharing as specified in the covered person's insurer's plan, as if the health care service is provided by an in-network health care provider; and

(4) An insurer shall not discriminate in the form of payment for any covered in-network health care service solely on the basis that the covered person was referred for the health care by an out-of-network health care provider.

(c) The commissioner is authorized to propose rules for legislative approval in accordance with §29A-3-1 *et seq*. of this code, to implement the provisions of this section.

(d) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2020. The amendments made to this article during the 2025 regular session of the Legislature are effective on January 1, 2026. This section applies to all policies, contracts, plans, or agreements, subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(e) If under federal law application of subsection (b) of this section would result in Health Savings Account ineligibility under Section 223 of the Internal Revenue Code, this requirement shall apply only for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code: *Provided*, That with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, the requirements of subsection (b) of this section shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

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

SERVICE CORPORATIONS.

§33-24-7t. Fairness in Cost-Sharing Calculation.

(a) As used in this section:

"Average allowed amount" means the average of all contractually agreed upon amounts paid by an insurer to a health care provider or other entity participating in the insurer's network. The average shall be calculated according to payments within a reasonable amount of time not to exceed one calendar year. The insurance commissioner may approve methodologies for calculating the average allowed amount that are based on any of the following: a specific covered person's insurer, all insurer plans offered in the state by a specific insurer, or a geographic area.

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

"Discounted cash price" means the price charged to individuals who pay cash(or cash equivalent) for an individual item or service or service package.

"Drug" means the same as the term is defined in §30-5-4 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" means the same as that term is defined in §33-51-3 of this code.

(b) 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 42 U.S.C. § 18022(c) and 42 U.S.C. § 300gg-6(b):

(1) An insurer shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person; ~~and~~

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

(3) A covered person who elects to receive a covered health care service at a discounted cash price that is below the average allowed amount shall receive credit toward the covered person's in-network cost-sharing as specified in the covered person's insurer's plan, as if the health care service is provided by an in-network health care provider; and

(4) An insurer shall not discriminate in the form of payment for any covered in-network health care service solely on the basis that the covered person was referred for the health care by an out-of-network health care provider.

(c) The commissioner is authorized to propose rules for legislative approval in accordance with §29A-3-1 *et seq*. of this code, to implement the provisions of this section.

(d) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2020. The amendments made to this article during the 2025 regular session of the Legislature are effective on January 1, 2026. This section applies to all policies, contracts, plans, or agreements subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(e) If under federal law application of subsection (b) of this section would result in Health Savings Account ineligibility under Section 223 of the Internal Revenue Code, this requirement shall apply only for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code: *Provided*, That with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, the requirements of subsection (b) of this section shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8q. Fairness in Cost-Sharing Calculation.

(a) As used in this section:

"Average allowed amount" means the average of all contractually agreed upon amounts

paid by an insurer to a health care provider or other entity participating in the insurer's network. The average shall be calculated according to payments within a reasonable amount of time not to exceed one calendar year. The insurance commissioner may approve methodologies for calculating the average allowed amount that are based on any of the following: a specific covered person's insurer, all insurer plans offered in the state by a specific insurer, or a geographic area.

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

"Discounted cash price" means the price charged to individuals who pay cash (or cash equivalent) for an individual item or service or service package.

"Drug" means the same as the term is defined in §30-5-4 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" means the same as that term is defined in §33-51-3 of this code.

(b) 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 42 U.S.C. § 18022(c) and 42 U.S.C. § 300gg-6(b):

(1) An insurer shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person; ~~and~~

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

(3) A covered person who elects to receive a covered health care service at a discounted cash price that is below the average allowed amount shall receive credit toward the covered person's in-network cost-sharing as specified in the covered person's insurer's plan, as if the health care service is provided by an in-network health care provider; and

(4) An insurer shall not discriminate in the form of payment for any covered in-network health care service solely on the basis that the covered person was referred for the health care by an out-of-network health care provider.

(c) The commissioner is authorized to propose rules for legislative approval in accordance with §29A-3-1 *et seq*. of this code, to implement the provisions of this section.

(d) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2020. The amendments made to this article during the 2025 regular session of the Legislature are effective on January 1, 2026. This section applies to all policies, contracts, plans, or agreements, subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(e) If under federal law application of subsection (b) of this section would result in Health Savings Account ineligibility under Section 223 of the Internal Revenue Code, this requirement shall apply only for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code: *Provided*, That with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, the requirements of subsection (b) of this section shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8t. Fairness in Cost-Sharing Calculation.

(a) As used in this section:

"Average allowed amount" means the average of all contractually agreed upon amounts paid by an insurer to a health care provider or other entity participating in the insurer’s network. The average shall be calculated according to payments within a reasonable amount of time not to exceed one calendar year. The insurance commissioner may approve methodologies for calculating the average allowed amount that are based on any of the following: a specific covered

person's insurer, all insurer plans offered in the state by a specific insurer, or a geographic area.

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

"Discounted cash price" means the price charged to individuals who pay cash (or cash equivalent) for an individual item or service or service package.

"Drug" means the same as the term is defined in §30-5-4 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" means the same as that term is defined in §33-51-3 of this code.

(b) 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 42 U.S.C. § 18022(c) and 42 U.S.C. § 300gg-6(b):

(1) An insurer shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person; ~~and~~

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

(3) A covered person who elects to receive a covered health care service at a discounted cash price that is below the average allowed amount shall receive credit toward the covered person's in-network cost-sharing as specified in the covered person's insurer's plan, as if the health care service is provided by an in-network health care provider; and

(4) An insurer shall not discriminate in the form of payment for any covered in-network health care service solely on the basis that the covered person was referred for the health care by an out-of-network health care provider.

(c) The commissioner is authorized to propose rules for legislative approval in accordance

with §29A-3-1 *et seq*. of this code, to implement the provisions of this section.

(d) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2020. The amendments made to this article during the 2025 regular session of the Legislature are effective on January 1, 2026. This section applies to all policies, contracts, plans, or agreements, subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(e) If under federal law application of subsection (b) of this section would result in Health Savings Account ineligibility under Section 223 of the Internal Revenue Code, this requirement shall apply only for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code: *Provided*, That with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, the requirements of subsection (b) of this section shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

NOTE: The purpose of this bill is to provide for the administration of cost-sharing calculations, define terms, and setting an effective date.

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