WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

Introduced

House Bill 5459

FISCAL NOTE

By Delegates Rohrbach, Criss, Riley, and Ellington

[Introduced February 12, 2026; referred to the

Committee on Finance]

A BILL to amend and reenact §11-27-10a of the Code of West Virginia, 1931, as amended, relating to the health care provider tax on managed care organizations.

Be it enacted by the Legislature of West Virginia:

ARTICLE 27. HEALTH CARE PROVIDER TAXES.

§11-27-10a. Imposition of tax on managed care organizations.

(a) *Imposition of tax*. — For the privilege of holding a certificate of authority within this state to establish or operate a "health maintenance organization" pursuant to §33-25A-4 of this code (hereinafter "certified HMO"), there is hereby levied and shall be collected from every such certified HMO an annual broad-based health care-related tax.

(b) *Rate and measure of tax*. ~~(i) Prior to July 1, 2022, the tax imposed by this section shall be based on the following rates applied to each taxable health plan's total Medicaid member months within tiers I, II, and III, and to non-Medicaid member months within tiers IV and V:~~

~~(1) Tier I — $35 for each Medicaid member month under 250,000;~~

~~(2) Tier II — $20 for each Medicaid member month between 250,000 and 500,000;~~

~~(3) Tier III — $1 for each Medicaid member month greater than 500,000;~~

~~(4) Tier IV — 25 cents for each non-Medicaid member month under 150,000; and~~

~~(5) Tier V — 10 cents for each non-Medicaid member month of 150,000 or more.~~

~~(ii) On and after July 1, 2022, the tax imposed by this section shall be based on the following rates applied to each taxable health plan's total Medicaid member months within tiers I, II, and III, and to non-Medicaid member months within tiers IV and V:~~

~~(1) Tier I — $36.26 for each Medicaid member month under 250,000;~~

~~(2) Tier II — $20.72 for each Medicaid member month between 250,000 and 500,000;~~

~~(3) Tier III — $1.036 for each Medicaid member month greater than 500,000;~~

~~(4) Tier IV — 25.9 cents for each non-Medicaid member month under 150,000; and~~

~~(5) Tier V — 10.36 cents for each non-Medicaid member month of 150,000 or more.~~

~~(iii) On July 1, 2023, and every July 1 thereafter, the tax rates for each tier will be increased~~

~~by the greater of either 0.0% or the average West Virginia Medicaid Managed Care capitation rate change from the two preceding fiscal years ending on June 30: *Provided*, That any increase shall meet the requirements in 42 C.F.R.§ 433.68.~~

~~(1) The average West Virginia Medicaid Managed Care capitation rate change will be calculated by the West Virginia Bureau for Medical Services from the initial SFY rate certifications as follows:~~

~~(A) The monthly membership weights by rate cell and month will be determined based on the projected member months by rate cell from the most recent initial SFY rate certification.~~

~~(B) For each of the two preceding fiscal years, to determine the total projected premium payments for each year, the West Virginia Bureau for Medical Services will multiply the initial SFY certified capitation rates net of directed payments by the monthly membership weights by rate cell and month as determined in §11-27-10a(b)(iii)(1)(A).~~

~~(C) For each of the two preceding fiscal years, the West Virginia Bureau for Medical Services will divide the total projected premium payments as determined in §11-27-10a(b)(iii)(1)(B) by the total enrollment to determine the average premium payment for each fiscal year.~~

~~(D) To determine the average West Virginia Medicaid Managed Care capitation rate change from the preceding two fiscal years, the West Virginia Bureau for Medical Services will divide the most recent fiscal year's average premium payment by the earlier fiscal year's average premium payment and subtract 1.~~

~~(2) Before July 1, 2023, and every July 1 thereafter, the West Virginia Bureau for Medical Services will certify to the Tax Commissioner the capitation rate change from the preceding two fiscal years, the calculation used in making that determination, and whether the increase meets the requirements of federal and state law for permissible health care-related taxes.~~

~~(3) Using the certified calculations from the West Virginia Bureau for Medical Services, the Tax Commissioner will publish, by Administrative Notice, before July 1 of each year the rates for~~

~~the next tax year applicable to each taxable health plan's total Medicaid member months within tiers I, II, and III, and to non-Medicaid member months within tiers IV and V.~~

(i) Beginning July 1, 2026, the tax imposed by this section shall be two and one-half percent of each certified HMO's gross premiums written in this state during each calendar quarter.

The tax rate in this subsection applies uniformly to all certified HMOs regardless of their share of Medicaid, Medicare, commercial, or non-Medicaid membership.

The tax imposed in this section does not apply to Medicare Advantage plans, a health plan issued by the West Virginia Public Employees Insurance Agency or a plan issued pursuant to the Federal Employees Health Benefits Act of 1959 (Public Law 86-382) to the extent the imposition of the tax under this section is preempted pursuant to 5 U.S.C. § 8909(f).

(c) *Definitions*. —

(1) "Managed care organization" or "MCO" means a certified HMO that provides health care services in the state of West Virginia. ~~to Medicaid members pursuant to an agreement or contract with the department.~~

~~(2) "Managed care plan" means an agreement or contract between the secretary and an MCO under which the MCO agrees to provide health care services to Medicaid members.~~

~~(3) "Medicaid member" means an individual enrolled in a taxable health plan who is a Medicaid beneficiary on whose behalf the department directly pays the health plan a capitated payment.~~

~~(4) "Medicaid member months" means the number of Medicaid members in a taxable health plan in each month or part of a month over the course of the tax year.~~

~~(5) "Non-Medicaid enrollee" means an individual who is an "enrollee", "subscriber", or "member", as those terms are defined in § 33-25A-2(8) of this code, in a taxable health plan who is not a Medicaid member: *Provided,* That this definition does not include Public Employees Retirement Agency members or Medicare Advantage members.~~

~~(6) "Non-Medicaid member months" means the number of non-Medicaid enrollees in a~~

~~taxable health plan in each month or part of a month over the course of the tax year, but does not include persons enrolled in either a health plan issued by the West Virginia Employees Insurance Agency or a plan issued pursuant to the Federal Employees Health Benefits Act of 1959 (Public Law 86-382) to the extent the imposition of the tax under this section is preempted pursuant to 5 U.S.C. § 8909(f).~~

~~(7)~~(2) "Taxable health plan" means: (i) An agreement or contract under which a certified HMO agrees to provide health care services in the state of West Virginia.~~to a non-Medicaid member in accordance with §33-25A-1 *et seq.* of this code; and (ii) a managed care plan.~~

~~(8)~~(3) "Tax year" means the fiscal year beginning on July 1 and ending on June 30.

~~(9) "Rate cell" means a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area.~~

~~(10)~~(4) "Gross Premiums" means the total amount of premiums, capitation payments, or other consideration received by the certified HMO for providing or arranging health care services to enrollees in this state. ~~"Initial SFY rate certification" means the MHT and MHP actuarial certifications as submitted to the Centers for Medicare and Medicaid Services prior to the start of the fiscal year and prior to any mid-year or other rate amendments.~~

(d) *Effective date*. —

(i) ~~Subject to an earlier termination pursuant to the terms of subdivision (ii) of this subsection, the tax imposed by this section shall be effective for three years beginning on the first day of the state fiscal year following a 30 day period after the secretary has posted notice on the department Internet website that approval had been received from the federal Centers for Medicare and Medicaid Services that the tax~~ On July 1, 2026, the tax structure under this section shall transition from the tiered member-month method to the gross premium assessment method described in subsection (b)(i) above subject to federal approval that the new tax structure imposed

by this ~~section~~ subsection is a permissible health care-related tax in accordance with 42 C.F.R. §433.68 and is therefore eligible for federal financial participation.

(ii) The tax imposed by this section shall be administered in accordance with the provisions of this article and the Tax Administration and Procedures act in §11-10-1 *et seq.* of this code: *Provided*, That the tax imposed by this section shall be automatically void if the Centers for Medicare and Medicaid Services determines that it is no longer a permissible health care-related tax that is eligible for federal financial participation.

(e) *Time for paying tax*. — Notwithstanding the provisions of §11-27-25 of this code, no taxes may be collected under this article until the department receives written notice that the federal Centers for Medicare and Medicaid Services has approved proposed Medicaid rates as actuarially sound for the taxable year in which the tax will be imposed.

NOTE: The purpose of this bill is to bring the health care provider tax on healthcare managed care organizations into compliance with new federal regulations.

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