WEST VIRGINIA LEGISLATURE

2020 REGULAR SESSION

Committee Substitute

for

Senate Bill 284

BY SENATORS CARMICHAEL (MR. PRESIDENT), CLINE,

MAYNARD, AND MARONEY, *original sponsors*

[Originating in the Committee on Banking and

Insurance; reported on February 7, 2020]

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

Be it enacted by the Legislature of West Virginia:

ARTICLE 53. WEST VIRGINIA HEALTH CARE CONTINUITY ACT.

§33-53-1. Short title.

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

§33-53-2. Definitions and applicability.

(a) For purposes of this article:

"Commissioner" means the commissioner of insurance.

"Program" means the West Virginia Patient Protection Program established pursuant to this article.

"Health insurance policy" means any individual insurance policy, group insurance policy, or other health benefit plan subject to the requirements of §33-15-1 *et seq.*, §33-16-1 *et seq.*, §33-25-1 *et seq.*, or §33-25A-1 *et seq.* of this code, but does not mean any policy offering only "excepted benefits" as that term is defined in §33-16-1a(f) of this code.

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

"Affiliation period" means a period that begins on a policyholder or dependent's enrollment date, runs concurrently with any waiting period under the health insurance policy, must expire

before coverage is effective, and during which the policy provider need not provide benefits for medical care and may not charge any premium to the policyholder or dependent.

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

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

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

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

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

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

(1) The State Commission on Health Care Continuity shall be created, and shall have the objective of identifying state or federal policies to replicate the tax credit authorized in Section

1401 of the Patient Protection and Affordable Care Act of 2010, P. L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P. L. 111-152, and codified in Section 16B of the Internal Revenue Code;

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

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

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

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

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

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

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

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

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

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

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

§33-53-4. Operation of the program.

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

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

§33-53-5. Actuarial analysis.

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

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

(b) Evaluate how funds that may currently be utilized to pay the Health Insurance Provider Fee (HIPF) or may be recovered pursuant to litigation related to the HIPF may be used to contribute to the funding of the program; and

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

§33-53-6. Program parameters.

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

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

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

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

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

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

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

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

§33-53-7. Approval by the Joint Committee on Government and Finance.

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

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

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

(b) The commissioner shall submit a report containing a detailed description of the proposed program to the Joint Committee on Government and Finance within 121 days after reporting the actuarial analysis required by §33-53-5 of this code to the Joint Committee on Government and Finance.

(c) The Joint Committee on Government and Finance shall meet to review and approve the actuarial analysis, the details of the program as determined by the commissioner, and any required funding. The committee may also take any other action with respect to the program deemed necessary by the committee.

§33-53-8. Required policy provisions.

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

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

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

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

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

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

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

(b) A policy issuer may:

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

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

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

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

(a) As used in this section:

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

"Drug" is defined in §30-5-4(19) 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" is defined in § 33-51-3 of this code.

"Premium adjustment percentage" for any calendar year means the percentage by which the average per capita premium for health insurance policies in this state in the previous calendar year, as determined by the commissioner not later than the first day of October of such preceding calendar year, exceeds such average per capita premium for 2019.

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

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

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

(c) 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 subsection (b) of this section:

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

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

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

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

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

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

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

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

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

(g) The commissioner shall promulgate rules to establish:

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

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

§33-53-11. Rulemaking authority.

(a) The commissioner shall promulgate rules:

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

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

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

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

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

(b) The commissioner shall establish these rules pursuant to §29A-3-1, *et seq*., of this code.

§33-53-12. Conflict of laws.

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

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