WEST VIRGINIA CODE CHAPTER 33 ARTICLE 48

§33-48-1. Definitions.

For purposes of this article:

(a) "Board" means the board of directors of the plan.

(b) "Church plan" has the meaning given such term under Section 3(33) of the federal Employee Retirement Income Security Act of 1974.

(c) "Commissioner" means the Insurance Commissioner of this state.

(d)(1) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(A) A group health plan;

(B) Health insurance coverage;

(C) Part A or Part B of Title XVIII of the Social Security Act;

(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

(E) Chapter 55 of Title 10, U.S.C.;

(F) A medical care program of the federal Indian health service or of a tribal organization;

(G) A state health benefits risk pool;

(H) A health plan offered under Chapter 89 of Title 5, U.S.C.;

(I) A public health plan as defined in federal regulations; or

(J) A health benefit plan under Section 5(e) of the federal Peace Corps Act (22 U.S.C. 2504 (e)).

(2) A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under this article, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

(e) "Department" means the Insurance Commissioner of West Virginia.

(f) "Dependent" means a resident spouse or resident unmarried child under the age of nineteen years, a child who is a student under the age of twenty-three years and who is financially dependent upon the parent or a child of any age who is disabled and dependent upon the parent.

(g) "Federally defined eligible individual" means an individual:

(1) For whom, as of the date on which the individual seeks coverage under this article, the aggregate of the periods of creditable coverage as defined in subsection (d) of this section is eighteen or more months;

(2) Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with such a plan;

(3) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (Medicare), or a state plan under Title XIX of Act (Medicaid) or any successor program and who does not have other health insurance coverage;

(4) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

(5) Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected this coverage; and

(6) Who has exhausted the continuation coverage under this provision or program, if the individual elected the continuation coverage described in subdivision (5) of this subsection.

(h) "Governmental plan" has the meaning given such term under Section 3(32) of the federal Employee Retirement Income Security Act of 1974 and any federal government plan.

(i) "Group health plan" means an employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care as defined in subsection (m) of this section and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise.

(j)(1) "Health insurance coverage" means any hospital and medical expense incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or healthcare services whether by insurance or otherwise.

(2) "Health insurance coverage" shall not include one or more, or any combination of, the following:

(A) Coverage only for accident or disability income insurance, or any combination thereof;

(B) Coverage issued as a supplement to liability insurance;

(C) Liability insurance, including general liability insurance and automobile liability

insurance;

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for on-site medical clinics; and

(H) Other similar insurance coverage, specified in federal regulations issued pursuant to PL 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Health insurance coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the coverage:

(A) Limited scope dental or vision benefits;

(B) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof; or

(C) Other similar, limited benefits specified in federal regulations issued pursuant to PL 104-191.

(4) "Health insurance coverage" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(A) Coverage only for a specified disease or illness; or

(B) Hospital indemnity or other fixed indemnity insurance.

(5) "Health insurance coverage" shall not include the following if offered as a separate policy, certificate or contract of insurance:

(A) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(B) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, U.S.C. (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(C) Similar supplemental coverage provided to coverage under a group health plan.

(k) "Health maintenance organization" means an organization licensed in this state pursuant to the provisions of article twenty-five-a of this chapter.

(l) "Insurer" means any entity that provides health insurance coverage in this state. For the purposes of this article, insurer includes an insurance company, a prepaid limited health service organization as operating under a certificate of authority pursuant to article twenty-five-d of this chapter, a fraternal benefit society, a health maintenance organization and any other entity providing a plan of health insurance coverage or health benefits subject to state insurance regulation.

(m) "Medical care" means amounts paid for:

(1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in subdivision (1) of this subsection; and

(3) Insurance covering medical referred to in subdivisions (1) and (2) of this subsection.

(n) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395, et seq., as amended.

(o) "Participating insurer" means any insurer providing health insurance coverage to residents of this state.

(p) "Plan" means the West Virginia health insurance plan as created in section two of this article.

(q) "Plan of operation" means the articles, bylaws and operating rules and procedures adopted by the board pursuant to section two of this article.

(r) "Resident" means an individual who has been legally domiciled in this state for a period of at least thirty days, except that for a federally defined eligible individual, there shall not be a thirty-day requirement. "Resident" also means an individual who is legally domiciled in this state on the date of application to the plan and is eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986.

(s) "Significant break in coverage" means a period of sixty-three consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

Terms within this article with meaning ascribed by federal law shall have the meaning as in effect in federal law December 31, 2003.

§33-48-2.

Repealed.

Acts, 2015 Reg. Sess., Ch. 53.

§33-48-3.

Repealed.

Acts, 2015 Reg. Sess., Ch. 53.

§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 $1 million 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.

§33-48-5. Unfair referral to plan.

It shall constitute an unfair trade practice for the purposes of article eleven of this chapter for an insurer, insurance agent or insurance broker to refer an individual employee to the plan, or arrange for an individual employee to apply to the plan, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

§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 July 1, 2004.

§33-48-7b. Surplus available to subsidize premiums.

Whenever the board determines that the account created pursuant to section seven-a of this article contains a surplus above those amounts necessary to provide fully for the expected costs of claims and other expenses listed in subsection (a), section seven of this article, the plan may use such surpluses to subsidize the premium of enrollees with an annual average household income at or below four hundred percent of the federal poverty level. The board may propose emergency rules and shall propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code to establish eligibility criteria for enrollees who are eligible for premium subsidy pursuant to this section.

§33-48-8. Benefits.

(a) The plan shall offer health care coverage consistent with comprehensive coverage to every eligible person who is not eligible for Medicare. The coverage to be issued by the plan, its schedule of benefits, exclusions and other limitations shall be established by the board and subject to the approval of the commissioner.

(b) In establishing the plan coverage, the board shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate; and promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance coverage provided through a representative number of large employers in the state.

(c) The board may adjust any deductibles and coinsurance factors annually according to the medical component of the consumer price index.

(d) Preexisting conditions. --

(1) Plan coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage as to any condition for which medical advice, care or treatment was recommended or received as to such conditions during the six-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual. The board may propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code to propose any other additional class of eligible individuals to which the preexisting condition exclusion may not apply.

(2) Subject to subdivision (1) of this subsection, the preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated: Provided, That:

(A) Application for pool coverage is made not later than sixty-three days following such involuntary termination and, in such case, coverage in the plan shall be effective from the date on which such prior coverage was terminated; and

(B) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to plan coverage.

(e) Nonduplication of benefits. --

(1) The plan shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance, whether provided on the basis

of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(2) The plan shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the plan may be reduced or refused as a set-off against any amount recoverable under this subdivision.

§33-48-9. Collective action.

Neither the participation in the plan as participating insurers, the establishment of rates, forms or procedures nor any other joint or collective action required by this article shall be the basis of any legal action, criminal or civil liability or penalty against the plan or any participating insurer.

§33-48-10. Taxation.

The plan established pursuant to this article shall be exempt from the premium taxes assessed under sections fourteen and fourteen-a, article three of this chapter.

§33-48-11.

Repealed.

Acts, 2009 Reg. Sess., Ch. 141.

§33-48-12. Effective date.

The provisions of this article shall become effective on July 1, 2004.