FILED

2006 APR -3 P 4: 17

OFFICE WEST VIRGINIA
SECRETARY OF STATE

HB 4021

WEST VIRGINIA LEGISLATURE

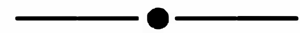
SECOND REGULAR SESSION, 2006

ENROLLED

COMMITTEE SUBSTITUTE
FOR

House Bill No. 4021

(By Delegates Mr. Speaker, Mr. Kiss, and Delegate Trump)
[By Request of the Executive]



Passed March 11, 2006

In Effect from Passage

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COMMITTEE SUBSTITUTE

FOR

H. B. 4021

(BY DELEGATES MR. SPEAKER, MR. KISS, AND DELEGATE TRUMP)
[BY REQUEST OF THE EXECUTIVE]

[Passed March 11, 2006; in effect from passage.]

AN ACT to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §5-16B-6d; to amend and reenact §9-2-9 of said code; to amend said code by adding thereto a new article, designated §16-2J-1, §16-2J-2, §16-2J-3, §16-2J-4, §16-2J-5, §16-2J-6, §16-2J-7, §16-2J-8 and §16-2J-9; to amend said code by adding thereto a new article, designated §16-29G-1, §16-29G-2, §16-29G-3, §16-29G-4, and §16-29G-5; and to amend said code by adding thereto a new article, designated §33-15D-1, §33-15D-2, §33-15D-3, §33-15D-4, §33-15D-5, §33-15D-6, §33-15D-7, §33-15D-8, §33-15D-9, §33-15D-10 and §33-15D-11, all relating to health care programs, authorizing an expansion of the children's health insurance program; providing criteria for the expansion; providing limitations based on funding availability; providing for a Medicaid management reporting system; providing for quarterly financial reports from the

Medicaid claims management system to the Legislative Oversight Commission on Health and Human Resources Accountability; requiring specific utilization data from the Medicaid claims management system; creating a pilot program authorizing participating health care clinics and private medical practitioners to provide primary and preventive health services for a prepaid fee; declaring legislative intent; authorizing approval of participants based on guidelines by the Health Care Authority and the Insurance Commissioner; requiring licensure by the Health Care Authority; authorizing the Insurance Commissioner to approve fees, marketing materials and forms and to certify financial soundness; authorizing study of the program by the Health Care Authority; providing for legislative rules; mandating a Health Care Authority report to the Legislative Oversight Commission on Health and Human Resources Accountability; setting grounds for revocation, suspension and failure to renew licenses; setting forth goals for health care reform; providing for an Interagency Health Council; providing for membership on the council; requiring council develop appropriate incentives, initiatives and assessments; providing for council to evaluate and recommend alternative reimbursement mechanisms; providing for council to establish an advisory committee; providing for council to measure and report on specific benchmarks; providing for council to make recommendations to the Legislative Oversight Commission on Health and Human Resources Accountability regarding the strategies to be used to meet the state's goals; requiring council to hold public hearings for the purpose of receiving relevant input; authorizing individual limited health benefits insurance plans; including preventive and primary care services; requiring approval of plans by Insurance Commissioner; providing eligibility requirements; setting forth statutory or regulatory provisions that do not apply to such plans; providing underwriting standards; continuing use of existing reimbursement rates; establishing criteria for filing and approval of premium rates; requiring certification of creditable coverage; authorizing Insurance

Commissioner to promulgate emergency rules; mandating disclaimer on policies; exempting plans from premium taxes; providing for severability; providing rule of construction; and creating penalties.

Be it enacted by the Legislature of West Virginia:

That the Code of West Virginia, 1931, as amended, be amended by adding thereto a new section, designated §5-16B-6d; that §9-2-9 of said code be amended and reenacted; that said code be amended by adding thereto a new article, designated §16-2J-1, §16-2J-2, §16-2J-3, §16-2J-4, §16-2J-5, §16-2J-6, §16-2J-7, §16-2J-8 and §16-2J-9; that said code be amended by adding thereto a new article, designated §16-29G-1, §16-29G-2, §16-29G-3, §16-29G-4 and §16-29G-5; and that said code be amended by adding thereto a new article, designated §33-15D-1, §33-15D-2, §33-15D-3, §33-15D-4, §33-15D-5, §33-15D-6, §33-15D-7, §33-15D-8, §33-15D-9, §33-15D-10 and §33-15D-11, all to read as follows:

CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE GOVERNOR, SECRETARY OF STATE AND ATTORNEY GENERAL; BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES, COMMISSIONS, OFFICES, PROGRAMS, ETC.

ARTICLE 16B. WEST VIRGINIA CHILDREN'S HEALTH INSURANCE PROGRAM.

§5-16B-6d. Modified benefit plan implementation.

1 (a) Upon approval by the Centers for Medicare and
2 Medicaid Services, the board shall implement a program for
3 uninsured children of families with income between two
4 hundred and three hundred percent of the federal poverty level.

5 (b) The benefit plans offered pursuant to this section shall
6 include services determined to be appropriate for children, but
7 may vary from those currently offered by the board.

8 (c) The board shall structure the benefit plans for this
9 expansion to include premiums, co-insurance or co-pays and
10 deductibles. The board shall develop the cost sharing features
11 in such a manner as to keep the program fiscally stable without
12 creating a barrier to enrollment. Such features may include
13 different cost-sharing features within this group based upon the
14 percentage of the federal poverty level.

15 (d) Children covered by an employer sponsored health
16 insurance plan during the previous twelve month period are not
17 eligible for coverage under this expansion, unless that coverage
18 is lost due to the parent's loss of employment.

19 (e) Provider reimbursement schedules shall be no lower
20 than the reimbursement provided for the same services under
21 the plans offered in article sixteen of this chapter.

22 (f) All provisions of this article are applicable to this
23 expansion unless expressly addressed in this section.

24 (g) Nothing in this section may be construed to require any
25 appropriation of state general revenue funds for the payment of
26 any benefit provided pursuant to this section, except for the
27 state appropriation used to match the federal financial participa-
28 tion funds. In the event that federal funds are no longer autho-
29 rized for participation by individuals eligible at income levels
30 above two hundred percent, the board shall take immediate
31 steps to terminate the expansion provided for in this section and
32 notify all enrollees of such termination. In the event federal
33 appropriations decrease for the programs created pursuant to
34 Title XXI of the Social Security Act of 1997, the board is
35 directed to make those decreases in this expansion program
36 before making changes to the programs created for those
37 children whose family income is less than two hundred percent
38 of the federal poverty level.

39 (h) The board is directed to report no less than quarterly to
40 the Legislative Oversight Commission on Health and Human
41 Resources Accountability on the development, implementation
42 and progress of the expansion authorized in this section.

CHAPTER 9. HUMAN SERVICES.

ARTICLE 2. COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES AND RESPONSIBILITIES GENERALLY.

§9-2-9. Secretary to develop medicaid monitoring and case management.

1 (a) The secretary of the department of health and human
2 resources shall:

3 (1) Develop a managed care system to monitor the services
4 provided by the medicaid program to individual clients;

5 (2) Develop an independent referral service, including the
6 review of individual cases for abuses of the program; and

7 (3) Develop a schedule for implementation of the managed
8 care and independent referral system. The managed care system
9 shall focus on, but not be limited to, the behavioral health and
10 mental health services.

11 (b) In addition thereto, and in accordance with applicable
12 federal medicaid laws, the secretary shall prepare recommenda-
13 tions, to be submitted to the joint committee on government and
14 finance. In developing recommendations the secretary shall
15 consider as options the following:

16 (1) Review of medicaid services which are optional under
17 federal medicaid law and identification of services to be
18 retained, reduced or eliminated;

19 (2) The elimination, reduction or phase-out of: (i) Services
20 which are not generally available to West Virginia citizens not
21 covered under the state's medicaid program; or (ii) services
22 which are not generally covered under group policies of
23 insurance made available to employees of employers within the
24 state;

25 (3) The elimination or reduction of services, or reduction of
26 provider reimbursement rates, for identified services of
27 marginal utility;

28 (4) Higher reimbursement rates for primary and preventive
29 care;

30 (5) Changes in fee structure, which may include a system
31 of prospective payments, and may include establishment of
32 global fees for identified services or diagnoses including
33 maternity care;

34 (6) Utilization caps for certain health care procedures;

35 (7) Restriction of coverage for cosmetic procedures;

36 (8) Identification of excessive use of certain health care
37 procedures by individuals and a policy to restrict excessive use;

38 (9) Identification of services which reduce the need for
39 more costly options for necessary care and retention or expan-
40 sion of those programs;

41 (10) Identification of services for which preauthorization is
42 a requirement for medicaid reimbursement;

43 (11) Recommendations relating to the development of a
44 demonstration project on long-term care, which demonstration
45 project may be limited to patients with alzheimer's disease;

46 (12) A policy concerning the department's procedures for
47 compliance, monitoring and inspection; and

48 (13) Such other options as may be developed.

49 (c) The secretary shall utilize in-state health care facilities
50 for inpatient treatment when such facilities are available. Prior
51 authorization, consistent with applicable federal law, shall be
52 required for out-of-state inpatient treatment.

53 (d) The secretary shall report to the joint committee on
54 government and finance on the development and implementa-
55 tion of medicaid programs that provide incentives to working
56 persons. The secretary shall consider: Subsidies for low income
57 working persons; individual or small employer buy-ins to the
58 state medicaid fund; prospective payment systems for primary
59 care physicians in underserved areas; and a system to improve
60 monitoring of collections, expenditures, service delivery and
61 utilization.

62 (e) The secretary shall report quarterly to the joint commit-
63 tee on government and finance regarding provider and facility
64 compliance with federal and state medicaid laws, including, but
65 not limited to, the following: The number of inspections
66 conducted during the previous quarter; description of programs,
67 services and facilities reviewed; findings; and recommendations
68 for corrections.

69 (f) The secretary shall, upon federal certification of the
70 claims management system, ensure that the claims management
71 system processing medicaid claims provides:

72 (1) Detailed quarterly financial reports to the Legislative
73 Oversight Commission on Health and Human Resources
74 Accountability;

75 (2) A management reporting system no later than the first
76 day of July, two thousand six; and

77 (3) Specific utilization data by provider, member eligibility
78 groups and service no later than the first day of October, two
79 thousand six.

CHAPTER 16. PUBLIC HEALTH.

ARTICLE 2J. PREVENTIVE CARE PILOT PROGRAM.

§16-2J-1. Legislative findings and statement of purpose.

1 (a) The Legislature finds that a program that would allow
2 health clinics and private medical practitioners to provide
3 primary and preventive health services for a prepaid fee would
4 enable more West Virginians to gain access to affordable health
5 care and to establish a medical home for purposes of receiving
6 primary and preventative healthcare services. By establishing
7 a pilot project for clinic-based health care, the Legislature
8 intends to enable state health and insurance officials to study
9 this method of delivering health services, to encourage all West
10 Virginians to establish a medical home and to determine the
11 success, continued need and feasibility of expanding such a
12 program and allowing similar programs to operate on a state-
13 wide basis.

14 (b) In carrying out this pilot program, it is the intent of the
15 Legislature to eliminate legal, statutory and regulatory barriers
16 to the establishment of pilot programs providing preventive and
17 primary care services for a prepaid fee; to encourage residents
18 of this State to establish and use a medical home; to expand
19 preventive and primary care services for the uninsured; and to
20 exempt health providers participating in the pilot program from
21 regulation as an insurer, the operation of insurance laws of the
22 state and all other laws inconsistent with the purposes of this
23 article.

§16-2J-2. Definitions.

1 For the purposes of this article, the following definitions
2 apply:

3 (1) "Dependent" has the same meaning set forth in subsec-
4 tion (d), section one-a, article sixteen, chapter thirty-three of
5 this code;

6 (2) "Family" means a subscriber and his or her dependents;

7 (3) "Medical home" means a team approach to providing
8 health care and care management. Whether involving a primary
9 care provider, specialist or sub-specialist, care management
10 includes the development of a plan of care, the determination of
11 the outcomes desired, facilitation and navigation of the health
12 care system, provision of follow-up and support for achieving
13 the identified outcomes. The medical home maintains a
14 centralized, comprehensive record of all health related services
15 to provide continuity of care.

16 (4) "Participating provider" means a provider under this
17 article that has been granted a license under this article to
18 operate as part of the pilot program;

19 (5) "Primary care" means basic or general health care
20 which emphasizes the point when the patient first seeks
21 assistance from the medical care system and the care of the
22 simpler and more common illnesses;

23 (6) "Provider" has the same meaning as "ambulatory health
24 care facility" set forth in subsection (b), section two, article
25 two-d of this chapter or "private office practice" as set forth in
26 subsection (a)(1), section four of said article;

27 (7) "Qualifying event" means loss of coverage due to: (i)
28 emancipation and resultant loss of coverage under a parent or
29 guardian's plan; (ii) divorce and loss of coverage under the

30 former spouse's plan; (iii) termination of employment and
31 resultant loss of coverage under an employer group plan:
32 *Provided,* That any rights of coverage under a COBRA continu-
33 ation plan as that term is defined in section three-m, article
34 sixteen, chapter thirty-three of this code, shall not be considered
35 coverage under an employer group health plan; (iv) involuntary
36 termination of coverage under a group health benefit plan
37 except for termination due to nonpayment of premiums or fraud
38 by the insured; or (v) exhaustion of COBRA benefits.

39 (8) "Subscriber" means any individual who subscribes to a
40 prepaid program approved and operated in accordance with the
41 provisions of this article, including an employee of any em-
42 ployer that has purchased a group enrollment on behalf of its
43 employees;

§16-2J-3. Authorization of preventive care pilot program; number of participants and sites; Health Care Authority considerations in selection of participating providers; funding.

1 (a) The Health Care Authority shall, in consultation with
2 the Insurance Commissioner, develop and implement during the
3 fiscal year beginning the first day of July, two thousand six, a
4 pilot program that permits no more than eight providers to
5 market and sell prepaid memberships entitling subscribers to
6 obtain preventive and primary health care from the participating
7 providers. Participating providers shall not be allowed to offer
8 their qualifying services at more than three separate sites. The
9 pilot program will be three years in length.

10 (b) Subject to the provisions of this article, the Health Care
11 Authority is vested with discretion to select providers using
12 diversity in practice organization, geographical diversity and
13 other criteria it deems appropriate. The Health Care Authority
14 also shall give consideration to providers located in rural areas
15 or serving a high percentage or large numbers of uninsured.

16 (c) In furtherance of the objectives of this article, the Health
17 Care Authority is authorized to accept any and all gifts, grants

18 and matching funds whether in the form of money or services:
19 *Provided*, That no gifts, grants and matching funds shall be
20 provided to the Health Care Authority by the State of West
21 Virginia to further the objectives of this article.

§16-2J-4. License for preventive care pilot program.

1 (a) No provider may participate in the pilot program
2 without first obtaining a preventive care pilot program license
3 from the Health Care Authority.

4 (b) The Health Care Authority shall determine the eligibil-
5 ity of providers to obtain licenses on the basis of applications
6 filed by providers on forms developed by the Health Care
7 Authority.

8 (c) Upon approval of the application, the participating
9 provider shall be granted a license to market and sell prepaid
10 health services under such terms as may be established in
11 guidelines developed by the Health Care Authority and the
12 Insurance Commissioner.

§16-2J-5. Insurance Commissioner approval of fees, marketing materials and forms and certification of financial condition; statement of services.

1 (a) The Insurance Commissioner shall develop guidelines
2 for all forms, marketing materials and fees proposed by
3 program applicants and participating providers under the same
4 criteria generally applicable to accident and sickness insurance
5 policies.

6 (b) All fees, marketing materials and forms proposed to be
7 used by any program applicant or participating provider are
8 subject to prior approval of the Insurance Commissioner, which
9 the Insurance Commissioner shall communicate to the Health
10 Care Authority. Fees may not be excessive, inadequate, or
11 unfairly discriminatory.

12 (c) The Insurance Commissioner must certify whether a
13 program applicant or, upon the request of the Health Care
14 Authority, an already participating provider is in a sound
15 financial condition and capable of operating in a manner that is
16 not hazardous to its prospective subscribers or the people of
17 West Virginia.

18 (d) Every subscriber is entitled to evidence of program
19 membership that shall contain a clear, concise and complete
20 statement of the services provided by the participating provider
21 and the benefits, if any, to which the subscriber is entitled; any
22 exclusions or limitations on the service, kind of service,
23 benefits, or kind of benefits, to be provided, including any
24 copayments; and where and in what manner information is
25 available as to how a service may be obtained.

26 (e) Fees paid to participating providers are not subject to
27 premium taxes and surcharges imposed on insurance compa-
28 nies.

29 (f) Notwithstanding the provisions of chapter thirty-three of
30 this code to the contrary, participation by providers in the
31 preventive care clinic-based pilot program created and autho-
32 rized pursuant to this article is not to be considered as providing
33 insurance or as offering insurance services. Such providers and
34 services are specifically excluded from the definitions of
35 "insurer" and "insurance" as defined in article one, chapter
36 thirty-three of this code, and are not subject to regulation by the
37 Insurance Commissioner except to the extent set forth in this
38 article, nor are participating providers unauthorized insurers
39 pursuant to section four, article forty-four of chapter thirty-three
40 of this code.

§16-2J-6. Rule-making authority.

1 The Health Care Authority and the Insurance Commis-
2 sioner shall promulgate joint rules as necessary to implement
3 the provisions of this article, including emergency rules,
4 promulgated pursuant to, chapter twenty-nine-a of this code.

§16-2J-7. Participating provider plan requirements: primary care services; prior coverage restrictions; notice of discontinuance or reduction of benefits.

1 In addition to the provisions of this article and any guide-
2 lines established by the Health Care Authority and Insurance
3 Commissioner, the plans offered pursuant to this article shall be
4 subject to the following:

5 (1) Each participating provider and site must offer a
6 minimum set of preventive and primary care services as
7 established by the Health Care Authority.

8 (2) No participating provider may offer: (i) an individual
9 plan to any individual who currently has a health benefit plan
10 or who was covered by a health benefit plan within the preced-
11 ing twelve months unless said coverage was lost due to a
12 qualifying event; (ii) a family plan to any family that includes
13 an adult to be covered who currently has a health benefit plan
14 or who was covered by a health benefit plan within the preced-
15 ing twelve months unless said coverage was lost due to a
16 qualifying event; or (iii) an employee group plan to any
17 employer that currently has a group health benefit plan or had
18 a group health benefit plan covering its employees within the
19 preceding twelve months.

20 (3) The Health Care Authority and the Insurance Commis-
21 sioner may, by legislative rule, permit participation by an
22 employer with a comprehensive high deductible plan if such
23 employer is able to demonstrate that such participation will not
24 negatively impact the coverage currently offered by such
25 employer.

26 (4) A participating provider must provide subscribers and,
27 where applicable, subscribers' employers with a minimum of
28 thirty days' notice of discontinuance or reduction of subscriber
29 benefits.

§16-2J-8. Guidelines for evaluation of the pilot program; report to Legislative Oversight Commission on Health and Human Resources Accountability.

1 (a) The Health Care Authority shall establish by guidelines
2 criteria to evaluate the pilot program and may require partici-
3 pating providers to submit such data and other information
4 related to the pilot program as may be required by the Health
5 Care Authority: *Provided,* That all personal income tax returns
6 filed pursuant to this article shall be treated as confidential
7 pursuant to the provisions of section five-d, article ten, chapter
8 11 of this code. For purposes of this article, this information
9 shall be exempt from disclosure under the freedom of informa-
10 tion act in article one, chapter twenty-nine-b of this code.

11 (b) No later than the first day of December, two-thousand
12 seven and annually thereafter during the operation of the pilot
13 program, the Health Care Authority must submit a report to the
14 Legislative Oversight Commission of Health and Human
15 Resources Accountability as established in article twenty-nine-e
16 of this chapter on progress made by the pilot project including
17 suggested legislation, necessary changes to the pilot program
18 and suggested expansion of the pilot program.

§16-2J-9. Grounds for refusal to renew; revocation and suspension of pilot program license; penalties; termination of suspension, reissuance and renewal of license.

1 (a) The Health Care Authority may after notice and hearing
2 refuse to renew, or may revoke or suspend the license of a
3 participating provider, in addition to other grounds therefor in
4 this article, if the participating provider:

5 (1) Violates any provision of this article;

6 (2) Fails to comply with any lawful rule or order of the
7 Health Care Authority;

8 (3) Is operating in an illegal, improper or unjust manner;

9 (4) Is found by the Insurance Commissioner to be in an
10 unsound condition or in such condition as to render its further
11 operation in West Virginia hazardous to its subscribers or to the
12 people of West Virginia;

13 (5) Compels subscribers under its contract to accept less
14 service than due them or to bring suit against it to secure full
15 service when it has no substantial defense;

16 (6) Refuses to be examined or to produce its accounts,
17 records and files for examination by the insurance commis-
18 sioner when requested to do so pursuant to section five of this
19 article;

20 (7) Fails to pay any final judgment rendered against it in
21 West Virginia within thirty days after the judgment became
22 final or time for appeal expired, whichever is later;

23 (8) Fails to pay when due to the state of West Virginia any
24 taxes, fees, charges or penalties.

25 (b) In addition to or in lieu of refusing to renew, revoking
26 or suspending the license of a participating provider in any
27 case, the Health Care Authority may, by order, require the
28 participating provider to pay to the state of West Virginia a
29 penalty in a sum not exceeding five thousand dollars for each
30 violation. Upon the failure of the provider to pay such penalty
31 within thirty days after notice thereof, the Health Care Author-
32 ity shall revoke or suspend the license of such participating
33 provider.

34 (c) When any license has been revoked or suspended or
35 renewal thereof refused, the Health Care Authority may reissue,
36 terminate the suspension of or renew such license when it is
37 determined that the conditions causing such revocation,
38 suspension or refusal to renew have ceased to exist and are
39 unlikely to recur.

ARTICLE 29G. INTERAGENCY HEALTH COUNCIL.

§16-29G-1. Purpose and scope.

1 The purpose of this article is to establish the standards and
2 criteria for evaluating the unmet health care needs within this
3 state, to evaluate methods to meet those needs and to set forth
4 recommendations related to services provided and services
5 needed, access issues, and related financing proposals.

§16-29G-2. Legislative findings and goals.

1 (a) The Legislature finds that the general welfare and well-
2 being of the citizens of the state is greatly affected by their
3 health status. The Legislature further finds that many of the
4 citizens have unmet health care needs, which impairs their
5 ability to lead full and productive lives. The Legislature further
6 finds that the current health care system is sufficiently funded
7 to meet those needs, but is not currently structured to ade-
8 quately and uniformly meet the state-wide needs of the popula-
9 tion. The Legislature further finds that reforms to the health
10 care delivery system, including the reimbursement structure,
11 may address the inequities in access, the inequities in funding
12 and result in a modified system that meets the needs of the state
13 and its citizens.

14 (b) In consideration of the need for health care reform, the
15 Legislature adopts the following goals:

16 (1) Access. West Virginia policy will reflect that access to
17 health care is a public good. West Virginia shall develop
18 strategies for having an integrated health care system that will
19 attempt to provide all West Virginians, regardless of their age,
20 employment, economic status, or their town of residency,
21 access to affordable, high quality health care that is financed in
22 a fair and equitable manner.

23 (A) In order to develop an integrated health care delivery
24 system, the state shall consider promoting local or regional
25 collaborative efforts among provider groups that are designed
26 to use available resources in a more equitable and efficient
27 fashion.

28 (B) To improve access to health care, the state shall
29 consider methods to expand benefits over time after meeting
30 appropriate benchmarks set forth in section four of this article.
31 A process will be developed to define the benefits, taking into
32 consideration scientific evidence, available funds and the values
33 and priorities of West Virginia citizens.

34 (2) It is of critical importance that health care costs are
35 brought under control. Likewise, it is essential that cost
36 containment initiatives address both the financing of health care
37 and the delivery and quality of health services offered in West
38 Virginia. To ensure financial sustainability of any proposed
39 plan, the state is committed to the extent possible to slow the
40 rate of growth of health care costs by the year two thousand ten.
41 Strategies for containing costs may include consideration of:

42 (A) A budgeting process for hospitals and other health care
43 providers as determined by the council established pursuant to
44 this article;

45 (B) Increased consumer access to health care price and
46 quality information;

47 (C) Promotion of self-care and healthy lifestyles;

48 (D) Enhanced prescription drug initiatives;

49 (E) Funding of chronic care initiatives;

50 (F) Investments in health information technology;

51 (G) Alignment of health care professional reimbursement
52 with best practices and outcomes rather than utilization; and

53 (H) Development of a long-term strategy for integrating the
54 health care delivery system as well as a strategy for integrating
55 health care policy, planning, and regulation within government.

56 (3) Quality. West Virginia's health delivery system should
57 model continuous improvement of health care quality and
58 safety. The tools and resources necessary to make informed use

59 of all health care services should be available to all West
60 Virginians. The state should look to incentives to health care
61 professionals and facilities to provide the best and most
62 appropriate care to West Virginians. The state's role in improv-
63 ing quality and safety should be through coordination of health
64 care policy, planning and regulation.

65 (4) Equitable Financing. The health care system in West
66 Virginia should be funded fairly and equitably. All residents
67 should have access to health care and all participating residents
68 should contribute to its cost.

69 (c) No private cause of action, either express or implied, is
70 created by or otherwise arises from the enactment, provisions
71 or implementation of this article.

§16-29G-3. Interagency council created; duties.

1 (a) There is hereby created the "Interagency Health Coun-
2 cil" consisting of the chairperson of the Health Care Authority,
3 the Insurance Commissioner, the secretary of the Department
4 for Health and Human Resources, the director of the Public
5 Employees Insurance Agency, and the director of the Children's
6 Health Insurance Program, and such other government agency
7 persons as may be deemed necessary by the council. Each ex-
8 officio member of the council may appoint a designee. The
9 council shall be chaired jointly by the chairperson of the Health
10 Care Authority and the Insurance Commissioner until the
11 Governor appoints another chairperson or co-chairpersons. The
12 council shall:

13 (1) Identify and report emerging trends and behaviors
14 among various participants in the health care system;

15 (2) Develop incentives to contain costs and methods to
16 assess the effectiveness of cost-containment efforts;

17 (3) Develop quality of care initiatives;

18 (4) Direct the studies required to accomplish the goals of
19 this section;

20 (5) Assess the feasibility of a publicly financed reinsurance
21 program for all health plans doing business in West Virginia;

22 (6) Recommend alternative reimbursement mechanisms for
23 health services that encourage cost effectiveness, improve the
24 quality of care, increase efficiency, reward primary care
25 practices that prevent chronic illnesses, avoid preventable
26 hospitalizations, and reduce long-term costs to the system;

27 (7) Assess whether any federal programs including, but not
28 limited to, Medicaid and the Children's Health Insurance
29 Program could be used to expand services if it is determined to
30 be the most cost effective means available;

31 (8) Receive reports and analysis from the West Virginia
32 Health Information Network established in article twenty nine-
33 g, chapter sixteen of this code and ensure that this information
34 is integrated into health planning;

35 (9) Collaborate with any entity charged with responsibility
36 for the development of a behavioral health plan to ensure a fully
37 integrated system including both physical and mental health;

38 (10) Receive input and make recommendations, generally,
39 to the Senate and House committees on Health and Finance, and
40 the Joint Committee on Government and Finance regarding the
41 long-term development of policies and programs designed to
42 ensure that West Virginia is moving towards an integrated
43 system of care that provides all citizens of West Virginia access
44 to affordable, high quality health care that is financed in a fair
45 and equitable manner.

46 (b) The council shall establish committees and subcommit-
47 tees to assist in their work.

48 (c) The council shall propose demonstration or pilot
49 projects designed to contain health care costs and improve the

50 delivery and quality of health care including, but not limited to,
51 a demonstration project to establish a regional system with
52 providers and hospitals working cooperatively to provide and
53 coordinate health care for all residents of the region.

54 (d) The council shall establish an advisory committee to
55 study a payment and regulatory system that provides incentives
56 to improve patient safety and quality while controlling the rate
57 of growth of health care expenditures below current projected
58 growth rates. The study shall include consideration of such
59 items as hospital services, budgeting processes, efficient and
60 economic operations, performance standards, utilization and
61 inflation benchmarks, estimated cost shifts, uncompensated
62 care, government payors, and the impact of the state health
63 plan. The council shall review the work of the advisory com-
64 mittee and report its findings and recommendations to the
65 Legislature prior to the first day of January, two thousand eight.

66 (e) The council shall report to the Joint Committee on
67 Government and Finance on an annual basis the estimated cost
68 shift to the private sector created by the federal and state
69 government payors. Government payors include, but are not
70 limited to, the Bureau for Medical Services, the Children's
71 Health Insurance Program, Workers' Compensation and the
72 Public Employees Insurance Agency.

73 (f) The council may request analysis from appropriate state
74 agencies as needed. The agencies shall report this information
75 at such times as determined necessary to fulfill the council's
76 oversight responsibilities.

§16-29G-4. Benchmarks and schedule.

1 (a) On or before the first day of January, two-thousand
2 seven and each year thereafter, the council shall recommend to
3 the Legislative Commission on Health and Human Resources
4 Accountability those strategies that could move the state toward
5 the goals established in this article.

6 (b) Prior to making recommendations the council shall find
7 that the appropriate benchmarks for the strategy being recom-
8 mended have been met:

9 (1) Financing necessary to support the recommendations is
10 cost-neutral or less expensive with respect to the health care
11 system and will not require more money than is projected to be
12 spent in the existing system by West Virginia employers and
13 individuals through taxes, premiums, and out-of-pocket
14 expenses;

15 (2) Administrative bureaucracy and costs will decrease as
16 a percentage of total health care spending;

17 (3) Quality of care will be improved; and

18 (4) The future costs of health care will be less than the
19 current growth rate, or the resources will be allocated in a
20 manner that is more efficient and cost-effective, based on
21 progress in implementing the following cost containment
22 measures:

23 (A) Payment system to hospitals;

24 (B) Increased consumer access to health care price and
25 quality information;

26 (C) Promotion of self-care and healthy lifestyles;

27 (D) Enhanced prescription drug initiatives developed in
28 cooperation with the pharmaceutical advocate;

29 (E) Funding of chronic care initiatives;

30 (F) Investments in health information technology;

31 (G) Alignment of health care professional reimbursement
32 with best practices and outcomes rather than utilization; and

33 (H) The creation of additional federally qualified health
34 centers (FQHC) or FQHC look-alikes if data supports this effort
35 and the federal government so approves.

36 (c) Recommendations to the Legislature shall include an
37 assessment of the cost savings or the reallocation of resources,
38 increased access, improvements in quality and delivery,
39 administrative simplification, fairness and equity in financing,
40 continuity of coverage, and financial sustainability.

§16-29G-5. Public notice and hearings.

1 (a) In recognition of the importance of public engagement,
2 the council shall have four public hearings prior to the first day
3 of January, two thousand seven to solicit input from citizens,
4 employers, hospitals, health care professionals, insurers, other
5 stakeholders, and interested parties about health care.

6 (b) The council shall report no less than quarterly to the
7 Legislative Commission on Health and Human Resource
8 Accountability and the Joint Committee on Government and
9 Finance on the their activities and recommendations in health
10 care reform to date.

CHAPTER 33. INSURANCE.

ARTICLE 15D. INDIVIDUAL LIMITED HEALTH BENEFITS PLANS.

§33-15D-1. Declaration of legislative intent.

1 The Legislature recognizes that health insurance is priced
2 beyond the reach of many citizens who could benefit from a
3 basic health plan. One of the ways affordable premiums can be
4 obtained is by some combination of limiting benefits and
5 increasing copays or deductibles. In order to provide greater
6 access to such affordable plans, the Legislature has determined
7 that authorization of the sale of insurance policies with limited
8 benefits that would include physician, inpatient and outpatient
9 care, with an emphasis on preventive and primary care, will
10 serve to bring insurance coverage to many of those West
11 Virginians without any insurance coverage. It is, therefore, the

12 intent of the Legislature to introduce flexibility in the design of
13 health insurance plans to allow insurers to offer basic benefits,
14 including preventive and primary care services, at affordable
15 prices. This article may be known as the Affordable Health
16 Insurance Act.

§33-15D-2. Individual limited health benefits plans; approval by commissioner; eligibility of individuals.

1 (a) As used in this article, "individual plan" means any plan
2 approved by the commissioner as an "individual limited health
3 benefits plan" in accordance with this article. Each such plan
4 constitutes a "particular type of accident and sickness insurance
5 coverage" for the purposes of subsection (a), section two-e,
6 article fifteen of this chapter.

7 (b) Notwithstanding any other provision of this code,
8 including provisions mandating the inclusion of certain benefits
9 in individual health insurance plans, upon filing with and
10 approval by the commissioner as an individual plan, any
11 insurer, including a health maintenance organization or health
12 service corporation, may offer the plan and rates associated
13 with the plan to individuals subject to the conditions of this
14 article.

15 (c) Any plan approved as an individual plan may, notwith-
16 standing any other provisions of this chapter and subject to any
17 other limitations on eligibility in this article or that may be
18 contained in rules proposed by the commissioner for approval
19 of the Legislature in accordance with article three, chapter
20 twenty-nine-a of this code, only be offered to an adult between
21 the ages of eighteen and sixty-four, inclusive, who:

22 (1) Has not had a health benefit plan covering him or her
23 for at least the prior twelve consecutive months: *Provided*, That
24 such a plan may not be offered to an employee of an employer
25 that offers a health benefits plan to its employees unless that
26 employee does not qualify for coverage under such employer
27 plan; or

28 (2) Has lost coverage due to a qualifying event. A qualify-
29 ing event shall include loss of coverage due to: (i) Emancipa-
30 tion and resultant loss of coverage under a parent's or guard-
31 ian's plan; (ii) divorce and loss of coverage under the former
32 spouse's plan; (iii) termination of employment and resultant
33 loss of coverage under an employer group plan except for loss
34 of employment for gross misconduct; or (iv) involuntary
35 termination of coverage under a group health benefit plan
36 except for termination due to nonpayment of premiums or fraud
37 by the insured.

38 (d) Every individual plan offered pursuant to this article
39 may limit eligibility on the basis of health status and an
40 individual who has been treated for a health condition in the
41 prior twelve months may have that condition excluded from
42 coverage for the first twelve months of the policy term.

§33-15D-3. Applicability of certain provisions; commissioner's authority to forbear from applying certain provisions.

1 (a) Only the following provisions of article fifteen of this
2 chapter apply to insurers offering individual plans pursuant to
3 this article: Sections two-a, two-b, two-d, two-e, three, four,
4 four-e, four-g, five, six, seven, eight, nine, eighteen and
5 nineteen: *Provided*, That the provisions of subsection (a),
6 section two-b, article fifteen of this chapter do not apply to such
7 plans if the Secretary of the United States Department of Health
8 and Human Services finds that the state is implementing an
9 acceptable alternative mechanism in accordance with the
10 provisions of 42 U. S. C. §300gg-44.

11 (b) Notwithstanding any other provision of this code, the
12 provisions of article twenty-eight of this chapter and legislative
13 rules regulating individual accident and sickness policies,
14 including the rule contained in series 12, title 114 of the West
15 Virginia Code of State Rules, do not apply to individual plans
16 issued pursuant to this article unless and to the extent specifi-
17 cally incorporated in rules promulgated pursuant to the author-
18 ity conferred by section seven of this article.

19 (c) The commissioner may forbear from applying any other
20 statutory or regulatory requirements to an insurer offering an
21 individual plan approved pursuant to this article, including any
22 requirements in articles twenty-four and twenty-five-a, pro-
23 vided that the commissioner first determines that such forbear-
24 ance serves the principles set forth in section one of this article.

§33-15D-4. Underwriting standards for individual plans.

1 Insurers shall underwrite individual plans in a comparable
2 manner as they underwrite other individual health insurance
3 plans governed by this chapter.

§33-15D-5. Reimbursement rates for individual plans.

1 Insurers shall reimburse providers pursuant to reimburse-
2 ment rates previously negotiated with the providers.

§33-15D-6. Filing and approval of rates.

1 (a) Premium rate charges for any individual plans shall:

2 (1) Be reasonable in relation to the benefits available under
3 the policy; and

4 (2) Notwithstanding the provisions of section one, article
5 sixteen-b of this chapter, be filed with the commissioner for a
6 waiting period of thirty days before the charges become
7 effective. At the expiration of thirty days the premium rate
8 charges filed are deemed approved unless prior thereto the
9 charges have been affirmatively approved or disapproved by the
10 commissioner.

11 (b) The commissioner shall disapprove premium rates that
12 are not in compliance with the requirements of any rule
13 promulgated pursuant to section seven of this article. The
14 commissioner shall send written notice of the disapproval to the
15 insurer. The commissioner may approve the premium rates
16 before the thirty-day period expires by giving written notice of
17 approval.

§33-15D-7. Certification of creditable coverage.

1 An insurer offering individual plans pursuant to the
2 provisions of this article shall provide certification of creditable
3 coverage in the same manner as provided in section three-m,
4 article sixteen of this chapter.

§33-15D-8. Emergency rules authorized.

1 The commissioner shall promulgate emergency and
2 legislative rules under the provisions of article three, chapter
3 twenty-nine-a of this code on or before the first day of Septem-
4 ber, two thousand six, to prescribe requirements regarding
5 ratemaking, which may include rules establishing loss ratio
6 standards for individual plans; to place further limitations on
7 the eligibility of individuals; to determine what medical
8 treatments, procedures and related health services benefits must
9 be included in such individual plans; and to provide for any
10 other matters deemed necessary to further the intent of this
11 article. In determining what medical treatments, procedures and
12 related health services benefits must be included in such plans,
13 the commissioner shall consider their effectiveness in improv-
14 ing the health status of individuals, their impact on maintaining
15 and improving health and on reducing the unnecessary con-
16 sumption of health care services and their impact on the
17 affordability of health care coverage.

§33-15D-9. Disclaimer.

1 Each individual plan issued pursuant to this article shall
2 include the following disclaimer printed in boldface type and
3 located in a prominent portion of each policy, subscriber
4 contract and certificate of coverage: "THIS LIMITED INDI-
5 VIDUAL HEALTH BENEFITS PLAN DOES NOT PROVIDE
6 COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC
7 OR LIMITED BENEFITS POLICY AND CONTAINS SPE-
8 CIFIC DOLLAR LIMITS THAT WILL BE PAID FOR
9 MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED.
10 IF THE COST OF SERVICES EXCEEDS THOSE LIMITS,
11 THE BENEFICIARY AND NOT THE INSURER IS RESPON-
12 SIBLE FOR PAYMENT OF THE EXCESS AMOUNTS".

§33-15D-10. Exemption from premium taxes.

1 Products authorized under this article are exempt from the
2 premium taxes and surcharges assessed under article three of
3 this chapter.

§33-15D-11. Severability; controlling provisions.

1 (a) If any provision of this act or the application thereof to
2 any person or circumstance is for any reason held to be invalid,
3 the remainder of the act and application of such provision to
4 other persons or circumstances shall not be affected thereby.

5 (b) To the extent that provisions of this article differ from
6 those contained elsewhere in this chapter, the provisions of this
7 article control.

That Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

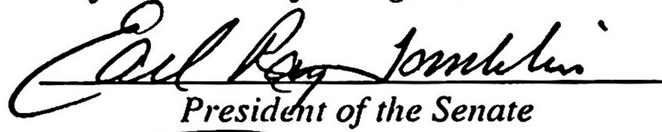
Chairman House Committee

Originating in the House.

In effect from passage.

Clerk of the Senate

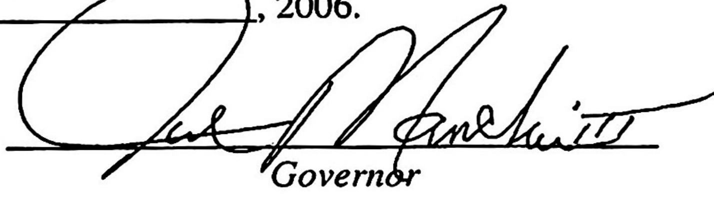
Clerk of the House of Delegates



President of the Senate

Speaker of the House of Delegates

The within is approved this the 3rd day of April, 2006.



Governor

PRESENTED TO THE
GOVERNOR

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