WEST VIRGINIA LEGISLATURE
SECOND REGULAR SESSION, 2006

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ENROLLED

COMMITTEE SUBSTITUTE FOR
House Bill No. 4021

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

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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.

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

(b) The benefit plans offered pursuant to this section shall include services determined to be appropriate for children, but may vary from those currently offered by the board.
(c) The board shall structure the benefit plans for this expansion to include premiums, co-insurance or co-pays and deductibles. The board shall develop the cost sharing features in such a manner as to keep the program fiscally stable without creating a barrier to enrollment. Such features may include different cost-sharing features within this group based upon the percentage of the federal poverty level.

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

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

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

(g) Nothing in this section may be construed to require any appropriation of state general revenue funds for the payment of any benefit provided pursuant to this section, except for the state appropriation used to match the federal financial participation funds. In the event that federal funds are no longer authorized for participation by individuals eligible at income levels above two hundred percent, the board shall take immediate steps to terminate the expansion provided for in this section and notify all enrollees of such termination. In the event federal appropriations decrease for the programs created pursuant to Title XXI of the Social Security Act of 1997, the board is directed to make those decreases in this expansion program before making changes to the programs created for those children whose family income is less than two hundred percent of the federal poverty level.
(h) The board is directed to report no less than quarterly to the Legislative Oversight Commission on Health and Human Resources Accountability on the development, implementation 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.

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

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

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

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

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

(1) Review of medicaid services which are optional under federal medicaid law and identification of services to be retained, reduced or eliminated;
(2) The elimination, reduction or phase-out of: (i) Services which are not generally available to West Virginia citizens not covered under the state's medicaid program; or (ii) services which are not generally covered under group policies of insurance made available to employees of employers within the state;

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

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

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

(6) Utilization caps for certain health care procedures;

(7) Restriction of coverage for cosmetic procedures;

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

(9) Identification of services which reduce the need for more costly options for necessary care and retention or expansion of those programs;

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

(11) Recommendations relating to the development of a demonstration project on long-term care, which demonstration project may be limited to patients with alzheimer's disease;
(12) A policy concerning the department’s procedures for compliance, monitoring and inspection; and

(13) Such other options as may be developed.

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

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

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

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

(1) Detailed quarterly financial reports to the Legislative Oversight Commission on Health and Human Resources Accountability;
(2) A management reporting system no later than the first day of July, two thousand six; and

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

CHAPTER 16. PUBLIC HEALTH.

ARTICLE 2J. PREVENTIVE CARE PILOT PROGRAM.

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

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

(b) In carrying out this pilot program, it is the intent of the Legislature to eliminate legal, statutory and regulatory barriers to the establishment of pilot programs providing preventive and primary care services for a prepaid fee; to encourage residents of this State to establish and use a medical home; to expand preventive and primary care services for the uninsured; and to exempt health providers participating in the pilot program from regulation as an insurer, the operation of insurance laws of the state and all other laws inconsistent with the purposes of this article.
§16-2J-2. Definitions.

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

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

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

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

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

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

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

(7) "Qualifying event" means loss of coverage due to: (i) emancipation and resultant loss of coverage under a parent or guardian’s plan; (ii) divorce and loss of coverage under the
former spouse's plan; (iii) termination of employment and resultant loss of coverage under an employer group plan: Provided, That any rights of coverage under a COBRA continuation plan as that term is defined in section three-m, article sixteen, chapter thirty-three of this code, shall not be considered coverage under an employer group health plan; (iv) involuntary termination of coverage under a group health benefit plan except for termination due to nonpayment of premiums or fraud by the insured; or (v) exhaustion of COBRA benefits.

(8) "Subscriber" means any individual who subscribes to a prepaid program approved and operated in accordance with the provisions of this article, including an employee of any employer that has purchased a group enrollment on behalf of its 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.

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

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

(c) In furtherance of the objectives of this article, the Health Care Authority is authorized to accept any and all gifts, grants
and matching funds whether in the form of money or services:

Provided, That no gifts, grants and matching funds shall be provided to the Health Care Authority by the State of West Virginia to further the objectives of this article.

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

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

(b) The Health Care Authority shall determine the eligibility of providers to obtain licenses on the basis of applications filed by providers on forms developed by the Health Care Authority.

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

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

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

(b) All fees, marketing materials and forms proposed to be used by any program applicant or participating provider are subject to prior approval of the Insurance Commissioner, which the Insurance Commissioner shall communicate to the Health Care Authority. Fees may not be excessive, inadequate, or unfairly discriminatory.
(c) The Insurance Commissioner must certify whether a program applicant or, upon the request of the Health Care Authority, an already participating provider is in a sound financial condition and capable of operating in a manner that is not hazardous to its prospective subscribers or the people of West Virginia.

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

(e) Fees paid to participating providers are not subject to premium taxes and surcharges imposed on insurance companies.

(f) Notwithstanding the provisions of chapter thirty-three of this code to the contrary, participation by providers in the preventive care clinic-based pilot program created and authorized pursuant to this article is not to be considered as providing insurance or as offering insurance services. Such providers and services are specifically excluded from the definitions of “insurer” and “insurance” as defined in article one, chapter thirty-three of this code, and are not subject to regulation by the Insurance Commissioner except to the extent set forth in this article, nor are participating providers unauthorized insurers pursuant to section four, article forty-four of chapter thirty-three of this code.

§16-2J-6. Rule-making authority.

The Health Care Authority and the Insurance Commissioner shall promulgate joint rules as necessary to implement the provisions of this article, including emergency rules, 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.

In addition to the provisions of this article and any guidelines established by the Health Care Authority and Insurance Commissioner, the plans offered pursuant to this article shall be subject to the following:

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

(2) No participating provider may offer: (i) an individual plan to any individual who currently has a health benefit plan or who was covered by a health benefit plan within the preceding twelve months unless said coverage was lost due to a qualifying event; (ii) a family plan to any family that includes an adult to be covered who currently has a health benefit plan or who was covered by a health benefit plan within the preceding twelve months unless said coverage was lost due to a qualifying event; or (iii) an employee group plan to any employer that currently has a group health benefit plan or had a group health benefit plan covering its employees within the preceding twelve months.

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

(4) A participating provider must provide subscribers and, where applicable, subscribers' employers with a minimum of thirty days' notice of discontinuance or reduction of subscriber benefits.
§16-2J-8. Guidelines for evaluation of the pilot program; report to Legislative Oversight Commission on Health and Human Resources Accountability.

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

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

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

(1) Violates any provision of this article;

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

(3) Is operating in an illegal, improper or unjust manner;
(4) Is found by the Insurance Commissioner to be in an unsound condition or in such condition as to render its further operation in West Virginia hazardous to its subscribers or to the people of West Virginia;

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

(6) Refuses to be examined or to produce its accounts, records and files for examination by the insurance commissioner when requested to do so pursuant to section five of this article;

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

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

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

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

ARTICLE 29G. INTERAGENCY HEALTH COUNCIL.
§16-29G-1. Purpose and scope.

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

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

(a) The Legislature finds that the general welfare and well-being of the citizens of the state is greatly affected by their health status. The Legislature further finds that many of the citizens have unmet health care needs, which impairs their ability to lead full and productive lives. The Legislature further finds that the current health care system is sufficiently funded to meet those needs, but is not currently structured to adequately and uniformly meet the state-wide needs of the population. The Legislature further finds that reforms to the health care delivery system, including the reimbursement structure, may address the inequities in access, the inequities in funding and result in a modified system that meets the needs of the state and its citizens.

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

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

(A) In order to develop an integrated health care delivery system, the state shall consider promoting local or regional collaborative efforts among provider groups that are designed to use available resources in a more equitable and efficient fashion.
(B) To improve access to health care, the state shall consider methods to expand benefits over time after meeting appropriate benchmarks set forth in section four of this article. A process will be developed to define the benefits, taking into consideration scientific evidence, available funds and the values and priorities of West Virginia citizens.

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

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

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

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

(D) Enhanced prescription drug initiatives;

(E) Funding of chronic care initiatives;

(F) Investments in health information technology;

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

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

(3) Quality. West Virginia’s health delivery system should model continuous improvement of health care quality and safety. The tools and resources necessary to make informed use
of all health care services should be available to all West Virginians. The state should look to incentives to health care professionals and facilities to provide the best and most appropriate care to West Virginians. The state's role in improving quality and safety should be through coordination of health care policy, planning and regulation.

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

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

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

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

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

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

(3) Develop quality of care initiatives;
(4) Direct the studies required to accomplish the goals of this section;

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

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

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

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

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

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

(b) The council shall establish committees and subcommittees to assist in their work.

(c) The council shall propose demonstration or pilot projects designed to contain health care costs and improve the
delivery and quality of health care including, but not limited to, a demonstration project to establish a regional system with providers and hospitals working cooperatively to provide and coordinate health care for all residents of the region.

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

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

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

§16-29G-4. Benchmarks and schedule.

(a) On or before the first day of January, two-thousand seven and each year thereafter, the council shall recommend to the Legislative Commission on Health and Human Resources Accountability those strategies that could move the state toward the goals established in this article.
(b) Prior to making recommendations the council shall find that the appropriate benchmarks for the strategy being recommended have been met:

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

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

(3) Quality of care will be improved; and

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

(A) Payment system to hospitals;

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

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

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

(E) Funding of chronic care initiatives;

(F) Investments in health information technology;

(G) Alignment of health care professional reimbursement with best practices and outcomes rather than utilization; and
(H) The creation of additional federally qualified health centers (FQHC) or FQHC look-alikes if data supports this effort and the federal government so approves.

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

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

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

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

CHAPTER 33. INSURANCE.

ARTICLE 15D. INDIVIDUAL LIMITED HEALTH BENEFITS PLANS.

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

The Legislature recognizes that health insurance is priced beyond the reach of many citizens who could benefit from a basic health plan. One of the ways affordable premiums can be obtained is by some combination of limiting benefits and increasing copays or deductibles. In order to provide greater access to such affordable plans, the Legislature has determined that authorization of the sale of insurance policies with limited benefits that would include physician, inpatient and outpatient care, with an emphasis on preventive and primary care, will serve to bring insurance coverage to many of those West Virginians without any insurance coverage. It is, therefore, the
intent of the Legislature to introduce flexibility in the design of
health insurance plans to allow insurers to offer basic benefits,
including preventive and primary care services, at affordable
prices. This article may be known as the Affordable Health
Insurance Act.

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

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

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

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

(1) Has not had a health benefit plan covering him or her
for at least the prior twelve consecutive months: Provided, That
such a plan may not be offered to an employee of an employer
that offers a health benefits plan to its employees unless that
employee does not qualify for coverage under such employer
plan; or
(2) Has lost coverage due to a qualifying event. A qualifying event shall include loss of coverage due to: (i) Emancipation and resultant loss of coverage under a parent's or guardian's plan; (ii) divorce and loss of coverage under the former spouse's plan; (iii) termination of employment and resultant loss of coverage under an employer group plan except for loss of employment for gross misconduct; or (iv) involuntary termination of coverage under a group health benefit plan except for termination due to nonpayment of premiums or fraud by the insured.

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

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

(b) Notwithstanding any other provision of this code, the provisions of article twenty-eight of this chapter and legislative rules regulating individual accident and sickness policies, including the rule contained in series 12, title 114 of the West Virginia Code of State Rules, do not apply to individual plans issued pursuant to this article unless and to the extent specifically incorporated in rules promulgated pursuant to the authority conferred by section seven of this article.
(c) The commissioner may forbear from applying any other statutory or regulatory requirements to an insurer offering an individual plan approved pursuant to this article, including any requirements in articles twenty-four and twenty-five-a, provided that the commissioner first determines that such forbearance serves the principles set forth in section one of this article.

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

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

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

Insurers shall reimburse providers pursuant to reimbursement rates previously negotiated with the providers.

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

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

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

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

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

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


The commissioner shall promulgate emergency and legislative rules under the provisions of article three, chapter twenty-nine-a of this code on or before the first day of September, two thousand six, to prescribe requirements regarding ratemaking, which may include rules establishing loss ratio standards for individual plans; to place further limitations on the eligibility of individuals; to determine what medical treatments, procedures and related health services benefits must be included in such individual plans; and to provide for any other matters deemed necessary to further the intent of this article. In determining what medical treatments, procedures and related health services benefits must be included in such plans, the commissioner shall consider their effectiveness in improving the health status of individuals, their impact on maintaining and improving health and on reducing the unnecessary consumption of health care services and their impact on the affordability of health care coverage.


Each individual plan issued pursuant to this article shall include the following disclaimer printed in boldface type and located in a prominent portion of each policy, subscriber contract and certificate of coverage: “THIS LIMITED INDIVIDUAL HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE 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.


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 was approved this the 3rd day of April, 2006.

Governor