WEST VIRGINIA LEGISLATURE
SEVENTY-NINTH LEGISLATURE
REGULAR SESSION, 2009

ENROLLED
COMMITTEE SUBSTITUTE
FOR

Senate Bill No. 408

(SENATORS MINARD, JENKINS, STOLLINGS AND KESSLER, original sponsor)

[Passed April 9, 2009; in effect ninety days from passage.]
ENROLLED

COMMITTEE SUBSTITUTE

FOR

Senate Bill No. 408

(SENATORS MINARD, JENKINS, STOLLINGS AND KESSLER, original sponsors)

[Passed April 9, 2009; in effect ninety days from passage.]

AN ACT to repeal §33-48-11 of the Code of West Virginia, 1931, as amended; to amend said code by adding thereto a new section, designated §33-48-7b; and to amend and reenact §33-48-8 of said code, all relating to the model health plan for uninsurable individuals; removing obsolete sunset provision; authorizing the use of surplus funds in the plan fund to subsidize premiums of certain enrollees; and permitting the board to propose legislative rules to propose additional classes of individuals to which the preexisting condition exclusion may not apply.

Be it enacted by the Legislature of West Virginia:

That §33-48-11 of the Code of West Virginia, 1931, as amended, be repealed; that said code be amended by adding thereto a new section, designated §33-48-7b; and that §33-48-8 of said code be amended and reenacted, all to read as follows:
ARTICLE 48. MODEL HEALTH PLAN FOR UNINSURABLE INDIVIDUALS ACT.

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

Whenever the board determines that the account created pursuant to section seven-a of this article contains a surplus above those amounts necessary to provide fully for the expected costs of claims and other expenses listed in subsection (a), section seven of this article, the plan may use such surpluses to subsidize the premium of certain low income enrollees whose eligibility shall be established by legislative rule. The board shall propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code to establish criteria for enrollees with low income eligible for premium subsidy pursuant to this section.


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

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

(d) Preexisting conditions. –

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

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

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

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

(e) Nonduplication of benefits. –

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

(2) The plan shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the plan may be reduced or refused as a set-off against any amount recoverable under this subdivision.
The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

Originated in the Senate.

In effect ninety days from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker House of Delegates

The within .................. approved .................. this the .......

Day of .................., 2009.

Governor