# WVHA LEGISLATIVE UPDATE

**December 10, 2025**

## December Interim Committee Activity

Legislators wrapped up interim meetings this week and there were several topics discussed directly impacting hospital operations and patient care delivery across the State. Below is a summary.

## Joint Health Committee Examines Hospital Price Transparency and Health Care Cost Drivers

The Joint Health Committee heard presentations on several issues including hospital price transparency, facility fees, mergers, the State lab, and "Food is Medicine."

The National Conference of State Legislatures (NSCL) staff opened the meeting with a briefing on what other states have done regarding efforts to address health care costs. U.S. health care spending is $4.9 trillion, or about $14,570 per person, and the higher cost is due to higher prices, not higher utilization. Commercial insurance has seen the largest increase in costs but many point to consolidation in hospitals and the acquisition of physicians as a driver of increased prices.

Before addressing state actions, NSCL noted the federal government already requires hospital price transparency for standard charges for items and services, such as gross charges, discounted rates, payer-specific rates, and de-identified minimum and maximum negotiated charges. Additionally, shoppable services should be available in plain language descriptions for health care consumers. According to CMS, more than 70% of hospitals are compliant with the federal requirements, but NSCL staff pointed out some groups report that hospital compliance is significantly lower.

NSCL noted state actions regarding hospital price transparency fall into two categories: **(1)** state enforcement of federal requirements, and **(2)** additional reporting requirements. The NCSL presentation is available **here** and the *WVHA Advocacy Brief* on hospital price transparency is available **here**.

Beyond hospital price transparency, NCSL reviewed state action regarding facility fees where four states have enacted legislation either requiring disclosure of the fee, reporting of revenue, and/or banning facilities in certain situations (i.e., telehealth). The *WVHA Advocacy Brief* on facility fees is available **here**.

Finally, NSCL reviewed state action on hospital consolidation and competition noting reporting requirements and state approval required for acquisitions over a certain threshold.

After the presentations, Chairman Evan Worrell, Chair of the House Health Committee asked how states have addressed lack of compliance with CMS federal hospital price transparency requirements. The NSCL staff noted some states have adopted increased fines and/or banning certain debt collection tools if a hospital is non-compliant.

The committee heard a presentation on the new state Center for Laboratory Sciences, expected to be completed in August 2028. After the West Virginia Department of Agriculture withdrew from the project, Marshall University and West Virginia University were added.

The committee also discussed "Food is Medicine." FARMacyWV presented its program providing nutrition education and food prescriptions to prevent, manage, and treat chronic disease. Poverty and food insecurity are linked to chronic diseases, which account for 90 percent of the $4.9 trillion in U.S. health care costs. West Virginia has a higher mortality rate than the national average, with 44 of 55 counties having food deserts. FARMacyWV provides $25 of fresh produce weekly to patients for 9 weeks through actual prescriptions from providers.

The West Virginia Food Is Medicine Coalition works to increase program visibility and highlight participant stories. Partners include FamilyCare health centers, Minnie Hamilton Health System, Roane General Hospital, Vandalia Health Network, WVU Medicine, Mountaineer Foodbank, and others. Policy opportunities include strengthening Managed Care contracts to address food insecurity, offering Food as Medicine as an MCO extra service, creating a pilot program for high-risk populations, and convening experts to explore data and technical assistance.

## LOCHHRA - *Rural Health Transformation Program Update*

Curtis Capehart, Director of Policy from the Governor's Office, briefed legislators on West Virginia's application for the Rural Health Transformation Program. West Virginia is eligible for more than $100 million per year over five years from the federal program, totaling over $500 million. The Governor's team completed an intensive six-week application process, engaging stakeholders including WVHA and the hospital field, through a statewide Request for Information that generated nearly 3,000 pages from 250+ responses, three roundtables with over three dozen organizations, and a tele-town hall. The application was submitted and confirmed by CMS on November 5.

**West Virginia’s Core Mission**

The program aims to make improved healthcare outcomes the foundation of West Virginia's economic strength. Poor health is the largest driver of low labor force participation in the state. By addressing health barriers and investing in prevention, the program seeks to restore working-age residents to health and productivity while building sustainable infrastructure beyond the five-year grant cycle.

**7 Key Initiatives**

Capehart summarized the following seven key initiatives of the State’s application:

1. **Connected Care Grid** integrates telehealth, remote patient monitoring, and local care coordination with real-time data analysis. It includes EMS treatment-in-place programs to reduce unnecessary emergency visits.
2. **Rural Health Link** creates a unified platform connecting non-emergency medical transport, public transit, and community ride programs. Vehicle and driver grants expand capacity while coordination with EMS and hospitals creates an efficient, data-driven system.
3. **Mountain State Care Force** addresses workforce challenges through early educational outreach, expanded rural residencies and fellowships, return-to-home scholarships, community college faculty positions, and learn-and-earn apprenticeships.

4. **Smart Care Catalyst** helps smaller hospitals and rural clinics modernize through technology grants, shared services, group purchasing, and transition support from fee-for-service to value-based payment models.
5. **Health to Prosperity Pipeline** connects health improvement to workforce re-entry through health-to-work and recovery-to-work initiatives, employer wellness partnerships, incentives for transitioning from Medicaid to commercial coverage, and outcome tracking.
6. **Personal Health Accelerator** shifts healthcare culture through wellness education and rewards, community initiative grants, support programs for mothers, infants, youth, and elderly, and integration of healthy living into schools, workplaces, and communities.
7. **Health Tech Appalachia** positions West Virginia as a medical technology leader by funding innovations in AI, digital health, and solutions for chronic illness, substance use, and maternal health through partnerships with universities, investors, and providers.

**Accountability Structure**

According to Capehart, CMS has established rigorous oversight including monthly status calls with all states and annual progress reviews. States not meeting goals risk having funds clawed back and redistributed to better-performing states. The program will be implemented through an RHTP Program Office within the Department of Health, with the Governor's Office providing strategic coordination. Grant recipients will face similar accountability requirements to ensure lasting benefits.

**Timeline and Legislative Action**

CMS must announce award decisions by December 31, 2024, with funding transfers expected in early January 2025. The legislature will need to appropriate federal funds, likely through supplemental appropriation or the budget bill. One identified legislative priority is reinstatement of the presidential fitness test. The application includes **no** commitments on Certificate of Need reform or scope of practice changes. Project documents will be available online this week.

## PEIA Approves 3% Premium Increase for FY 2027 – Lawmakers briefed on plan

The PEIA Finance Board recently approved premium increases and fee adjustments for the state's health coverage program beginning July 1, 2026. PEIA Director Brent Wolfingbarger presented the fiscal year 2027 financial plan to lawmakers this week. He reported on the following key approved changes:

**Premium Increases**

- 3% aggregate premium increase for both employees and retirees (Medicare and non-Medicare)
- This represents a significant reduction from earlier this year's increases of 14% for state employees, 16% for local government employees, and 12% for retirees
- Director Wolfingbarger noted that PEIA experienced no premium increases between 2018 and 2022 despite rising healthcare costs, necessitating larger adjustments in recent years

**Spousal Surcharge**

- Average family-tier spousal surcharge will increase by $200 per month to $550 per month
- This change is required to comply with state code mandating employees pay the actuarial value of coverage when their spouse has insurance available through another private employer
- This adjustment was the most contentious issue raised during November public hearings

**Retiree Fund Adjustments**

- PAYGO premium transfer from active employee fund to retiree trust increases from $10 million to $55 million
- An additional $30 million in gains will transfer to the retiree premium stabilization reserve
- Director Wolfingbarger indicated actuaries initially proposed doubling retiree premiums, but these transfers help moderate retiree costs and improve the state's OPEB liability funding status

Legislator questions and discussion focused on the following key points:

**Tiered Spousal Surcharge** Lawmakers discussed implementing a tiered spousal surcharge based on employee salary, similar to the current premium structure. Senator Mike Oliverio (R-Monongalia) asked whether removing certain State Code provisions would allow PEIA to charge spouses using the same 10-tier structure used for employees. Director Wolfingbarger confirmed this would require legislative action but would provide salary-based flexibility.

**80-20 Contribution Mandate for Non-State Entities** Discussion centered on whether non-state entities (counties and municipalities) should follow the same 80-20 employer/employee cost-sharing mandate as state employers. Director Wolfingbarger indicated this warrants further study.

**Potential Legislative Implications**

As we move into the 2026 Regular Session, we can expect some of the following legislative proposals/discussion surfacing at the State Capitol:

- Possible legislation to allow tiered spousal surcharges based on employee income
- Further examination of cost-sharing requirements for non-state PEIA participants
- Continued focus on long-term sustainability of both active employee and retiree health coverage

## 2026 Legislative Session on the Horizon; WVHA Legislative Priorities identified

The 2026 Regular Legislative Session will convene on Jan. 14, 2026. In a recent op-ed for the *Charleston Gazette-Mail*, WVHA President and CEO Jim Kaufman highlighted WVHA's main legislative priorities for the upcoming year. The full op-ed can be found here. We are also making the media rounds in the weeks ahead of the session promoting our priorities and discussing the challenges and opportunities for the hospital field in West Virginia. The final 2026 Legislative Agenda will be distributed following formal Board approval on Dec. 18.

## Reminder: WVHA Advocacy Activities

The Association has organized several advocacy activities to ensure strong hospital representation throughout the legislative process. Registration is available here for our Feb. 11 Legislative Reception, Feb. 12 Legislative Breakfast and Hospital Day at the Capitol Activities and our Feb. 13 Member Wide Wrap-Up Call.

If you have any questions about legislative activity, please contact me. Thanks

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