ENGROSSED

COMMITTEE SUBSTITUTE

FOR

**H. B. 2960**

(By Delegates Guthrie, Hartman and Manchin)

(Introduced March 18, 2013; referred to the Committee on Banking and Insurance then the Judiciary)

[March 29, 2013]

A BILL to repeal §33-25C-5, §33-25C-6, §33-25C-7, §33-25C-9 and §33-25C-11 of the Code of West Virginia, 1931, as amended; and to amend said code by adding thereto a new article, designated §33-16H-1, §33-16H-2, §33-16H-3 and §33-16H-4, all relating to review of adverse determinations by health plan issuers; mandating utilization review and internal grievance procedures; providing for external review of adverse determinations; defining terms; providing for judicial review of certain decisions; providing for venue of judicial review; providing for continued benefits pending judicial review; providing for an award of attorneys fees; providing no new causes of action; preserving existing causes of action; repealing similar provisions applicable to only health maintenance organizations; and directing proposal and promulgation of rules.

"**ARTICLE 16H. REVIEW OF ADVERSE DETERMINATIONS.**

**§33-16H-1. Definitions.**

As used in this article:

(1) "Adverse determination" means a decision by or on behalf of an issuer to:

(A) Rescind coverage;

(B) Declare an individual not eligible to participate in the health benefit plan; or

(C) Deny, reduce or terminate payment for a benefit, or fail to make payment, in whole or in part, for a benefit, based on a determination that:

(i) The benefit is not covered; or

(ii) The benefit is experimental, investigational or does not meet the issuer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

(2) "External review" means a review of an adverse determination by an independent review organization.

(3) "Final adverse determination" means an adverse determination that has been upheld by the issuer at the completion of the internal grievance procedures or an adverse determination with respect to which the internal grievance procedures have been deemed exhausted.

(4) "Health plan issuer" or "issuer" means an entity required to be licensed under this chapter that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit

plan, including an accident and sickness insurance company, a health maintenance corporation, a health care corporation, a health or hospital service corporation, and a fraternal benefit society.

(5) "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by an issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including short-term and catastrophic health insurance policies and policies that pay on a cost-incurred basis, but excludes the excepted benefits defined in 42 U.S.C. §300gg-91 and policies, contracts, certificates or agreements excluded by rules promulgated pursuant to section four of this article.

(6) "Independent review organization" means an entity approved by the commissioner to conduct external reviews of final adverse determinations.

(7) "Utilization review" means a system for the evaluation of the necessity, appropriateness and efficiency of the use of health care services, procedure and facilities.

(8) "Rescission" means a discontinuance of coverage under a health benefit plan that has a retroactive effect or a cancellation. The term does not include a cancellation or discontinuation that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

**§33-16H-2. Issuer requirements.**

An issuer shall, in accordance with rules promulgated pursuant to section four of this article, develop processes for utilization

review and internal grievance procedures and shall make external review available with respect to all adverse determinations.

**§33-16H-3. Judicial review; enforcement; rules.**

(a) An individual or issuer may seek judicial review of a final decision rendered by an independent review organization by filing a petition in the circuit court of the county in which the individual resides, within sixty days after he or she receives notice of the decision. The issuer shall provide any service or pay any claim determined in a final administrative decision to be covered and medically necessary for the case under review during any period of judicial review until judicial review is complete and final, including any appeal. However, if the issuer initiates the appeal and the individual prevails in such appeal then the issuer shall be responsible for the reasonable attorneys fees of the individual.

(b) This article does not create any new cause of action or eliminate any presently existing cause of action.

(c) If an issuer seeks judicial review of a final decision, the issuer must file the petition in the circuit court of the county in which the individual resides.

**§33-16H-4. Rule-making authority; emergency rules; applicability.**

(a) The commissioner shall promulgate emergency rules and, in accordance with the provisions of article three, chapter twenty-nine-a of this code, shall propose legislative rules for approval by the Legislature, to implement the provisions of this article, including, but not limited to, rules to:

(1) Define the scope of the applicability of this article;

(2) Establish requirements for all issuers with regard to utilization review and for internal grievance procedures and external review of adverse determinations, which rules shall be based on the corresponding model acts adopted by the National Association of Insurance Commissioners and, with respect to external review, shall meet or exceed the minimum consumer protections established by the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152); and

(3) Provide for judicial review pursuant to subsection (b), section three of this article, which rules shall be based on the provisions of this code and rules governing judicial review of contested cases under the state administrative procedures act.

(b) Notwithstanding the provisions of section one, article twenty-three of this chapter; section four, article twenty-four of this chapter; section six, article twenty-five of this chapter; and section twenty-four, article twenty-five-a of this chapter, this article and the rules promulgated under this article are applicable to all health benefits plans and supersede any provisions to the contrary in this chapter or in any rules promulgated under this chapter.