WEST VIRGINIA LEGISLATURE

2016 REGULAR SESSION

Introduced

Senate Bill 409

BY SENATORS TAKUBO, PLYMALE, STOLLINGS AND

PREZIOSO

[Introduced January 27, 2016;

Referred to the Committee on Health and Human

Resources.]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §33-15F-1, §33-15F-2, §33-15F-3 and §33-15F-4, all relating to requiring any insurance company operating in this state be precluded from excluding any health-care provider who provides services to persons receiving federal health care subsidies; defining terms; prohibiting discrimination of health-care providers; providing for exceptions; granting rule-making authority to Insurance Commissioner; and setting out construction and applicability.

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 article, designated §33-15F-1, §33-15F-2, §33-15F-3 and §33-15F-4, all to read as follows:

ARTICLE 15F. NONDISCRIMATION BY PAYERS.

§33-15F-1. Definitions.

The following words and phrases when used in this chapter have the meanings given to them in this section unless the context clearly indicates otherwise:

(1) “Health care benefit plan” means an insurance policy, contract or plan that provides health care to participants or beneficiaries directly or through insurance, reimbursement or otherwise.

(2) “Health care payer” means an individual or entity that is responsible for providing or paying for all or part of the cost of health care services covered by a health care benefit plan and subject to the provisions of chapter thirty-three of this code.

(3) “Health care provider” means any physician licensed pursuant to the provision of articles three and fourteen of chapter thirty of this code or an entity subject to licensure pursuant to the provisions of article five-b, chapter sixteen of this code.

(4) “Medicaid” means a joint federal-state program that provides health care insurance to low-income persons codified at 42 U.S.C.A. § 1396.

(5) “Medicare” means a federally funded system of health and hospital insurance for persons aged sixty-five and older and for disabled persons codified at 42 U.S.C.A. §§ 1395 et seq.

(6) “Physician services” mean and are limited to those services furnished by a physician within the scope of the practice of medicine or osteopathy, as defined by the laws of this state, whether furnished in the physician's office, the recipient's home, a hospital, a skilled nursing facility or any other location. The term physicians' services includes those professional services directly furnished by a physician in the scope of his or her employment by a hospital. Other services rendered in conjunction with hospital-employed physicians' services, such as the use of hospital facilities, staff, equipment, drugs and supplies ordinarily furnished by a hospital, are not considered physicians' services pursuant to this section.

§33-15F-2. Discrimination against health care providers prohibited.

(a) A health care payer is required to contract with and to accept as a health care benefit plan participant any willing health care provider who also provides physician services to recipients of either Medicaid or Medicare.

(b) A health care payer may not discriminate against a provider of health care services who:

(1) Agrees to accept the health care payer's standard payment levels;

(2) Provides physician services as defined by this article to recipients of Medicaid and Medicare; and

(3) Meets and agrees to adhere to quality standards established by the health care payer.

§33-15F-3. Exceptions; rulemaking.

Any health care payer may request an exemption from contracting with individual payers for the requirements of this section by filing a request with the Office of the Insurance Commissioner. The Insurance Commissioner, in consultation with the West Virginia Board of Medicine, may propose rules for legislative approval in accordance with the provisions of article

three, chapter twenty-nine-a of this code to accomplish the requirements of this article and to establish a procedure for filing and granting of exemptions filed by a health care payer.

§33-15F-4. Construction and application.

(a) Construction --This article may not be construed to prohibit a health care payer from negotiating and paying rates higher than the health care payer's standard payment levels to one or more providers.

(b) Application --This article:

(1) Applies to all health care benefit plans that compensate providers on a fee-for-service basis, per diem or other nonrisk basis; and

(2) Does not apply to health care benefit plans regarding products that compensate providers on a capitated basis.

NOTE: The purpose of this bill is to require health insurers to contract with any physician or health care facility who also provides services to Medicaid and Medicare recipients.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.