

WEST VIRGINIA LEGISLATURE

2016 REGULAR SESSION

Introduced

House Bill 4593

BY DELEGATES COOPER, FLEISCHAUER, MANCHIN,
PUSHKIN, PERDUE, MOORE, CAMPBELL, BATES,
FAIRCLOTH, RODIGHIERO AND SKINNER

[Introduced February 17, 2016; Referred
to the Committee on Banking and Insurance then
Health and Human Resources.]

1 A BILL to amend and reenact §33-15-2a and §33-15-4, of the Code of West Virginia, 1931, as
 2 amended, and to amend said code by adding thereto three new sections designated §33-
 3 15-4m, §33-15-20a and §33-15-22, all related to defining surprise bills and health care
 4 providers, adding new disclosure requirements for health care providers, hospitals and
 5 insurers, adding the requirement that insurers develop an access plan for consumers, and
 6 establishing how surprise bills are to be handled in certain circumstances.

Be it enacted by the Legislature of West Virginia:

1 That §33-15-2a and §33-15-4 of the Code of West Virginia, 1931, as amended, be
 2 amended and reenacted; and that said code be amended by adding thereto three new sections,
 3 designated §33-15-4m, §33-15-20a and §33-15-22, all to read as follows:

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-2a. Definitions.

1 For purposes of this section and sections two-b, two-c, two-d, two-e, two-f, two-g and four-
 2 e:

3 (a) "Accident and sickness insurance coverage" means benefits consisting of medical care
 4 (provided directly, through insurance or reimbursement, or otherwise and including items and
 5 services paid for as medical care) under any hospital or medical service policy of certificate,
 6 hospital or medical service plan contract, or health maintenance organization contract offered by
 7 an insurer, but does not include short-term limited duration insurance.

8 (b) "Bona fide association" means an association which has been actively in existence for
 9 at least five years; has been formed and maintained in good faith for purposes other than obtaining
 10 insurance; does not condition membership in the association on any health status-related factor
 11 relating to an individual; makes accident and sickness insurance coverage offered through the
 12 association available to all members regardless of any health status-related factor relating to the
 13 members or individuals eligible for coverage through a member; does not make accident and
 14 sickness insurance coverage offered through the association available other than in connection

15 with a member of the association; and meets any additional requirements as may be set forth in
16 this chapter or by rule.

17 (c) "COBRA continuation provision" means any of the following:

18 (1) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of
19 such section insofar as it relates to pediatric vaccines;

20 (2) Part 6 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974,
21 other than Section 609 of such act; or

22 (3) Title XXII of the Public Health Service Act.

23 (d) "Creditable coverage" means, with respect to an individual, coverage of the individual
24 under any of the following:

25 (1) A group health plan;

26 (2) Accident and sickness insurance coverage;

27 (3) Part A or Part B of Title XVIII of the Social Security Act;

28 (4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits
29 under section 1928;

30 (5) Chapter 55 of Title 10 of the United States Code;

31 (6) A medical care program of the Indian Health Service or of a tribal organization;

32 (7) A state health benefits risk pool;

33 (8) A health plan offered under Chapter 89 of Title 5 of the United States Code;

34 (9) A public health plan (as defined in federal regulations); or

35 (10) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

36 The term "creditable coverage" does not include those benefits set forth in section two-g
37 of this article.

38 (e) "Eligible individual" means an individual:

39 (1) For whom, as of the date on which the individual seeks coverage, the aggregate period
40 of creditable coverage is eighteen months or more and whose most recent prior creditable

41 coverage was under a group health plan, governmental plan (as defined in section 3(32) of the
42 Employee Retirement Income Security Act of 1974), church plan (as defined in section 3(33) of
43 the Employee Retirement Income Security Act of 1974), or accident and sickness insurance
44 coverage offered in connection with any such plan;

45 (2) Who is not eligible for coverage under a group health plan, Part A or Part B of Title
46 XVIII of the Social Security Act, or state plan under Title XIX of such act (or any successor
47 program), and does not have other accident and sickness insurance coverage;

48 (3) With respect to whom the most recent prior creditable coverage was not terminated as
49 a result of fraud, intentional misrepresentation of material fact under the terms of the coverage,
50 or nonpayment of premium;

51 (4) Who did not turn down an offer of continuation of coverage under a COBRA
52 continuation provision or under a similar state program if it was offered; and

53 (5) Who, if the individual elected such continuation coverage, has exhausted that coverage
54 under the COBRA continuation provision or similar state program.

55 (f) "Group health plan" means an employee welfare benefit plan (as defined in section 3(1)
56 of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides
57 medical care to employees and their dependents (as defined under the terms of the plan) directly
58 or through insurance, reimbursement or otherwise.

59 (g) "Health care provider" means a person, partnership, corporation, facility, hospital or
60 institution licensed, certified or authorized by law to provide professional health care service in
61 this state to an individual during the individual's medical treatment, or behavioral health care,
62 treatment or confinement.

63 ~~(g)~~ (h) "Health status-related factor" means an individual's health status, medical condition
64 (including both physical and mental illnesses), claims experience, receipt of health care, medical
65 history, genetic information, and evidence of insurability (including conditions arising out of acts
66 of domestic violence) or disability.

67 ~~(h)~~ (i) "Higher-level coverage" means a policy form for which the actuarial value of the
68 benefits under the coverage is at least fifteen percent greater than the actuarial value of lower-
69 level coverage offered by the insurer in this state, and the actuarial value of the benefits under
70 the coverage is at least one hundred percent but not greater than one hundred twenty percent of
71 a weighted average.

72 ~~(i)~~ (j) "Individual market" means the market for accident and sickness insurance coverage
73 offered to individuals other than in connection with a group health plan.

74 ~~(j)~~ (k) "Insurer" means an entity licensed by the commissioner to transact accident and
75 sickness insurance in this state and subject to this chapter, but does not include a group health
76 plan or short term limited duration insurance.

77 ~~(k)~~ (l) "Lower-level coverage" means a policy form for which the actuarial value of the
78 benefits under the coverage is at least eighty-five percent but not greater than one hundred
79 percent of a weighted average.

80 ~~(l)~~ (m) "Medical care" means amounts paid for, or paid for insurance covering, the
81 diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose
82 of affecting any structure or function of the body, including the amounts paid for transportation
83 primarily for and essential to such care.

84 ~~(m)~~ (n) "Network plan" means accident and sickness insurance coverage of an insurer
85 under which the financing and delivery of medical care (including items and services paid for as
86 medical care) are provided, in whole or in part, through a definite set of providers under contract
87 with the insurer.

88 ~~(n)~~ (o) "Preexisting condition exclusion" means a limitation or exclusion of benefits relating
89 to a condition based on the fact that the condition was present before the date of enrollment for
90 coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or
91 received before such date.

92 (p) "Surprise bill" means an invoice for health care services, other than emergency

93 services, received by a patient in one of three circumstances:

94 (1) An insured receives services from an out-of-network health care provider at an in-
95 network hospital or ambulatory surgery center, where a participating health care provider is
96 unavailable or an out-of-network health care provider renders services without the patient's
97 knowledge.

98 (2) An insured receives services from an out-of-network health care provider, where the
99 services were referred by an in-network provider without the patient's express written
100 acknowledgment that the referral is to an out-of-network provider, and that the referral may result
101 in costs not covered in the health plan.

102 (3) An uninsured patient receives services at a hospital or ambulatory surgery center and
103 does not receive the disclosures required in subdivision (1), subsection (b), section four, article
104 fifteen, chapter thirty-three of this code.

105 ~~(e)~~ (g) "Weighted average" means the average actuarial value of the benefits provided by
106 all the accident and sickness insurance coverage issued (as elected by the insurer) either by that
107 insurer or by all insurers in this state in the individual accident and sickness market during the
108 previous year (not including coverage issued under this section), weighted by enrollment for the
109 different coverage.

§33-15-4. Required policy provisions.

1 Except as provided in section six of this article, each such policy delivered or issued for
2 delivery to any person in this state shall contain the provisions specified in this section in the
3 words in which the same appear in this section: *Provided*, That the insurer may, at its option,
4 substitute for one or more of such provisions corresponding provisions of different wording
5 approved by the commissioner which are in each instance not less favorable in any respect to the
6 insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing
7 in this section or, at the option of the insurer, by such appropriate individual or group captions or
8 subcaptions as the commissioner may approve.

9 (a) A provision as follows:

10 "Entire Contract; Changes: This policy, including the endorsements and the attached
11 papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid
12 until approved by an executive officer of the insurer and unless such approval be endorsed hereon
13 or attached hereto. No agent has authority to change this policy or to waive any of its provisions."

14 (b) A provision as follows:

15 "Time Limit on Certain Defenses:

16 (1) After two years from the date of issue of this policy no misstatements, except
17 fraudulent misstatements, made by the applicant in the application for such policy shall be used
18 to void the policy or to deny a claim for loss incurred or disability (as defined in the policy)
19 commencing after the expiration of such two-year period."

20 The foregoing policy provision shall not be so construed as to affect any legal requirement
21 for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the
22 application of subdivisions (a), (b), (c), (d) and (e) of section five of this article in the event of
23 misstatement with respect to age or occupation or other insurance. A policy which the insured
24 has the right to continue in force subject to its terms by the timely payment of premium (i) until at
25 least age fifty, or (ii) in the case of a policy issued after age forty-four, for at least five years from
26 its date of issue, may contain in lieu of the foregoing the following provision (from which the clause
27 in parentheses may be omitted at the insurer's option) under the caption "Incontestable":

28 "After this policy has been in force for a period of two years during the lifetime of the
29 insured (excluding any period during which the insured is disabled), it shall become incontestable
30 as to the statements contained in the application.

31 (2) No claim for loss incurred or disability (as defined in the policy) commencing after two
32 years from the date of issue of this policy shall be reduced or denied on the ground that a disease
33 or physical condition not excluded from coverage by name or specific description effective on the
34 date of loss had existed prior to the effective date of coverage of this policy."

35 (c) A provision as follows:

36 "Grace Period: A grace period of _____ (insert a number not less than §7'
37 for weekly premium policies, §10' for monthly premium policies and §31' for all other policies)
38 days will be granted for the payment of each premium falling due after the first premium, during
39 which grace period the policy shall continue in force."

40 (d) A provision as follows:

41 "Reinstatement: If any renewal premium be not paid within the time granted the insured
42 for payment, as subsequent acceptance of premium by the insurer or by any agent duly authorized
43 by the insurer to accept such premium, without requiring in connection therewith an application
44 for reinstatement, shall reinstate the policy: *Provided*, That if the insurer or such agent requires
45 an application for reinstatement and issues a conditional receipt for the premium tendered, the
46 policy will be reinstated upon approval of such application by the insurer, or lacking such approval,
47 upon the forty-fifth day following the date of such conditional receipt unless the insurer has
48 previously notified the insured in writing of its disapproval of such application. The reinstated
49 policy shall cover only loss resulting from such accidental injury as may be sustained after the
50 date of reinstatement and loss due to such sickness as may begin more than ten days after such
51 date. In all other respects the insured and insurer shall have the same rights thereunder as they
52 had under the policy immediately before the due date of the defaulted premium, subject to any
53 provisions endorsed hereon or attached hereto in connection with the reinstatement."

54 (e) A provision as follows:

55 "Notice of Claim: Written notice of claim must be given to the insurer within twenty days
56 after the occurrence or commencement of any loss covered by the policy, or as soon thereafter
57 as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the
58 insurer at _____ (insert the location of such office as the insurer may designate
59 for the purpose), or to any authorized agent of the insurer, with information sufficient to identify
60 the insured, shall be deemed notice to the insurer."

61 In a policy providing a loss-of-time benefit which may be payable for at least two years, an
62 insurer may at its option insert the following between the first and second sentences of the above
63 provision:

64 "Subject to the qualifications set forth below, if the insured suffers loss of time on account
65 of disability for which indemnity may be payable for at least two years, he or she shall, at least
66 once in every six months after having given notice of claim give to the insurer notice of
67 continuance of said disability, except in the event of legal incapacity. The period of six months
68 following any filing of proof by the insured or any payment by the insurer on account of such claim
69 or any denial of liability, in whole or in part, by the insurer shall be excluded in applying this
70 provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity
71 which would otherwise have accrued during the period of six months preceding the date on which
72 such notice is actually given."

73 (f) A provision as follows:

74 "Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant
75 such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished
76 within fifteen days after the giving of such notice the claimant shall be deemed to have complied
77 with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the
78 policy for filing proofs of loss, written proof covering the occurrence, the character and the extent
79 of the loss for which claim is made."

80 (g) A provision as follows:

81 "Proof of Loss: Written proof of loss must be furnished to the insurer at its said office in
82 case of claim for loss for which this policy provides any periodic payment contingent upon
83 continuing loss within ninety days after the termination of the period for which the insurer is liable
84 and in case of claim for any other loss within ninety days after the date of such loss. Failure to
85 furnish such proof within the time required shall not invalidate nor reduce any claim if it was not
86 reasonably possible to give proof within such time, provided such proof is furnished as soon as

87 reasonably possible and in no event, except in the absence of legal capacity, later than one year
88 from the time proof is otherwise required."

89 (h) A provision as follows:

90 "Time of Payment of Claims: Indemnities payable under this policy for any loss other than
91 loss for which this policy provides any periodic payment will be paid immediately upon receipt of
92 due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss
93 for which this policy provides periodic payment will be paid _____ (insert period for
94 payment which must not be less frequently than monthly) and any balance remaining unpaid upon
95 the termination of liability will be paid immediately upon receipt of due written proof."

96 (i) A provision as follows: "Payment of Claims: Indemnity for loss of life will be payable in
97 accordance with the beneficiary designation and the provisions respecting such payment which
98 may be prescribed herein and effective at the time of payment. If no such designation or provision
99 is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued
100 indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such
101 beneficiary or to such estate. All other indemnities will be payable to the insured."

102 The following provisions, or either of them, may be included with the foregoing provisions
103 at the option of the insurer:

104 "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured
105 or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may
106 pay such indemnity, up to an amount not exceeding \$_____ (insert an amount which shall
107 not exceed \$1,000), to any relative by blood or connection by marriage of the insured or
108 beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by
109 the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of
110 such payment."

111 "Subject to any written direction of the insured in the application or otherwise all or a
112 portion of any indemnities provided by this policy on account of hospital nursing, medical, or

113 surgical services may, at the insurer's option and unless the insured requests otherwise in writing
114 not later than the time of filing proofs of such loss, be paid directly to the hospital or person
115 rendering such services; but it is not required that the service be rendered by a particular hospital
116 or person."

117 (j) A provision as follows:

118 "Physical Examinations and Autopsy: The insurer at its own expense shall have the right
119 and opportunity to examine the person of the insured when and as often as it may reasonably
120 require during the pendency of a claim hereunder and to make an autopsy in case of death where
121 it is not forbidden by law."

122 (k) A provision as follows:

123 "Legal Actions: No action at law or in equity shall be brought to recover on this policy prior
124 to the expiration of sixty days after written proof of loss has been furnished in accordance with
125 the requirements of this policy. No such action shall be brought after the expiration of three years
126 after the time written proof of loss is required to be furnished."

127 (l) A provision as follows:

128 "Change of Beneficiary: Unless the insured makes an irrevocable designation of
129 beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the
130 beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to
131 any change of beneficiary or beneficiaries, or to any other changes in this policy."

132 The first clause of this provision, relating to the irrevocable designation of beneficiary, may
133 be omitted at the insurer's option.

134 (m) A provision as follows:

135 An access plan that includes the following components:

136 (1) The insurer's network, including how the use of telemedicine or telehealth or other
137 technology may be used to meet network access standards;

138 (2) The insurer's procedures for making and authorizing referrals within and outside its

139 network, if applicable;

(3) The insurer's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;

140 (4) The insurer's process for making available in consumer-friendly language the criteria
141 it has used to build its provider network, including information about the breadth of the network
142 and the criteria used to select or rank providers, which must be made available through the health
143 carrier's on-line and in-print provider directories;

144 (5) The insurer's efforts to address the needs of covered persons who may face barriers
145 to access to care, including, but not limited to, children with serious, chronic or complex medical
146 conditions, individuals with limited English proficiency and illiteracy, individuals with diverse
147 cultural and ethnic backgrounds, and individuals with physical and mental disabilities;

148 (6) The insurer's methods for assessing the health care needs of covered persons and
149 their satisfaction with services;

150 (7) The insurer's method of informing covered persons of the plan's services and features,
151 including but not limited to, the plan's grievance procedures, its process for choosing and
152 changing providers, its process for updating its provider directories for each of its network plans,
153 a statement of services offered, including those services offered through the preventative care
154 benefit, if applicable, and its procedures for providing and approving emergency and specialty
155 care;

156 (8) The insurer's system for ensuring the coordination and continuity of care for covered
157 persons referred to specialty physicians, for covered persons using ancillary services, including
158 social services and other community resources, and for ensuring appropriate discharge planning;

159 (9) The insurer's process for enabling covered persons to change primary care
160 professionals;

161 (10) The insurer's proposed plan for providing continuity of care in the event of contract
162 termination between the health carrier and any of its participating providers, or in the event of the

163 health carrier's insolvency or other inability to continue operations. The description shall explain
164 how covered persons will be notified of the contract termination, or the health carrier's insolvency
165 or other cessation of operations, and transferred to other providers in a timely manner;

166 (11) The insurer's process for monitoring access to physician specialist services in
167 emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory
168 services at their participating hospitals; and

169 (12) Any other information required by the commissioner to determine compliance with the
170 provisions of this article.

§33-15-4m. Required disclosures:

1 (a) Health care providers must:

2 (1) Disclose to patients and prospective patients, in writing or through their website, their
3 plan and hospital affiliations prior to the provision of nonemergency services and verbally at the
4 time an appointment is scheduled.

5 (2) An out of network provider must inform the patient, prior to providing nonemergency
6 services that (i) the actual or estimated amount for the service is available upon request, and (ii)
7 if requested, will be disclosed in writing with a warning that costs could go up if unanticipated
8 complications occur.

9 (b) Physicians, in addition to the foregoing, must provide a patient and the inpatient or
10 outpatient hospital in which the patient is scheduled for admission with the name, practice name,
11 mailing address and phone number of any other physician scheduled to treat the patient and
12 information as to how to determine the health plan in which the provider participates.

13 (c) Hospitals must post the following information on their website:

14 (1) Standard charges for services provided by the hospital, including diagnosis-related
15 groups (DRGs);

16 (2) The health plans in which they participate;

17 (3) A warning that: (i) Charges for health care provider's who provide services in the

18 hospital are not part of the hospital's charges; and (ii) health care providers who provide services
19 in the hospital may not be in the same networks as the hospital; and

20 (4) The name, address and phone number of both contracted specialty practice group
21 providers and employed physicians, together with information regarding how they can be
22 contacted to determine their plan affiliations.

23 (5) In addition, in the registration and admission materials provided in advance of the
24 provision of nonemergency services, hospitals must: (i) Advise patients to check with the health
25 care provider arranging their services to determine the name, address and phone number of any
26 other health care provider involved in the patient's care, and whether any employed or contracted
27 specialty physicians are expected to participate in the patient's care; and (ii) provide patients with
28 information regarding how they can timely determine the health plans in which the health care
29 providers participate.

30 (d) Health Plans shall:

31 (1) Provide information in writing and on the Internet that allows consumers to estimate
32 anticipated out-of-pocket costs for out of network services in a particular geographical area based
33 on the difference between what the insurer will reimburse for the out of network services and the
34 usual and customary costs for the out of network services.

35 (2) Upon request from an enrollee or prospective enrollee, disclose the approximate dollar
36 amount that the insurer will pay for a particular out of network service but that the approximation
37 is not binding on the insurer and may change.

§33-15-20a. Insurers requirements related to in-network and out of network providers.

1 (a) An insurer shall have a process to assure that a covered person obtains a covered
2 benefit at an in-network level of benefits from a nonparticipating provider, or shall make other
3 arrangements acceptable to the commissioner when:

4 (1) The insurer has a sufficient network, but has determined that it does not have a type
5 of provider available to provide the covered benefit to the covered person or it does not have a

6 participating provider available to provide the covered benefit without unreasonable travel or
7 delay; or

8 (2) The insurer has an insufficient number or type of participating providers available to
9 provide the covered benefit to the covered person without unreasonable travel or delay.

10 (b) The insurer shall specify the process a covered person may use to request access to
11 obtain a covered benefit from a nonparticipating out of network provider as provided in subsection
12 (a) of this section when:

13 (1) The covered person is diagnosed with a condition or disease that requires specialized
14 health care services or medical services; and

15 (2) The insurer:

16 (i) Does not have a network provider of the required specialty with the professional training
17 and expertise to treat or provide health care services for the condition or disease; or

18 (ii) Cannot provide reasonable access to a network provider with the required specialty
19 with the professional training and expertise to treat or provide health care services for the
20 condition or disease without unreasonable delay.

21 (c) The insurer shall treat the services the covered person receives from a nonnetwork
22 provider pursuant to subdivision two of subsection b of this section as if the services were provided
23 by a network provider.

24 (d) The process described in this section must ensure that requests to obtain a covered
25 benefit from a nonparticipating provider are addressed in a timely fashion appropriate to the
26 covered person's condition.

§33-15-22. Coverage of surprise bills.

1 (a) In order to be protected from surprise bills, the consumer must sign an assignment of
2 benefits form which will enable the provider to seek payment directly from the consumer's insurer
3 by submitting the assignment of benefit form along with a copy of the bill believed to be a surprise
4 bill. Upon payment of a reasonable payment of a surprise bill, the provider can dispute the amount

- 5 through an independent dispute resolution process established by the commissioner.
- 6 (b) The independent dispute process will consider, among other things, whether there is
- 7 a significant disparity between the fee charged by the health care provider as compared to other
- 8 fees paid to similarly qualified out-of-network providers in the same region, the level of training
- 9 and education of the health care provider, and the complexity and circumstances of the case.

NOTE: The purpose of this bill is to define surprise bills, to protect consumers from surprise bills in certain circumstances, to require additional disclosures by health care providers, hospitals and insurers and to require insurers to develop an access plan with certain components for consumers, and establishing how surprise bills are to be handled in certain circumstances.

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