WEST VIRGINIA LEGISLATURE

2017 REGULAR SESSION

ENGROSSED

Committee Substitute

for

House Bill 2301

BY DELEGATES SUMMERS AND ELLINGTON

[Originating in the Committee on the Judiciary]

A BILL to repeal §16-2J-1, §16-2J-2, §16-2J-3, §16-2J-4, §16-2J-5, §16-2J-6. §16-2J-7, §16-2J-8 and §16-2J-9 of the Code of West Virginia, 1931, as amended; and to amend said code by adding thereto a new article, designated §30-3F-1, §30-3F-2, §30-3F-3, §30-3F-4 and §30-3F-5, all relating to direct primary care; defining terms; permitting individuals to enter into agreements, for direct primary care with an individual or other legal entity authorized to provide primary care services, outside of an insurance plan or outside of the Medicaid or Medicare program and pay for the care outside of insurance plans and the Medicaid or Medicare program; providing that insurance benefits are not forfeited by certain purchases; providing that certain products are not the offer of insurance; providing that direct primary care membership agreement is not considered insurance; prohibiting direct primary care providers from billing third-party payers for services or products under the direct primary care membership agreement; providing that a direct primary care provider is not required to obtain certain credentials; prohibiting the billing of third party providers for direct primary care services; stating certain requirements for direct primary care membership agreement; providing rule-making authority by the West Virginia Board of Medicine; the West Virginia Board of Osteopathic Medicine and the West Virginia Board of Examiners for Registered Professional Nurses to effectuate the provisions of this new article; and authorizing civil penalties in the form of sanctions by the respective boards for violations that constitute unprofessional conduct.

Be it enacted by the Legislature of West Virginia:

That §16-2J-1, §16-2J-2, §16-2J-3, §16-2J-4, §16-2J-5, §16-2J-6, §16-2J-7, §16-2J-8 and §16-2J-9 of the Code of West Virginia, 1931, as amended, be repealed; and that said code be amended by adding thereto a new article, designated §30-3F-1, §30-3F-2, §30-3F-3, §30-3F-4 and §30-3F-5, all to read as follows:

~~ARTICLE 2J. PREVENTIVE CARE PILOT PROGRAM.~~

~~§16-2J-1. Legislative findings and statement of purpose.~~

~~(a) The Legislature finds that a program that would allow health clinics and private medical practitioners to provide primary and preventive health services for a prepaid fee would enable more West Virginians to gain access to affordable health care and to establish a medical home for purposes of receiving primary and preventative healthcare services. By establishing a pilot project for clinic-based health care, the Legislature intends to enable state health and insurance officials to study this method of delivering health services, to encourage all West Virginians to establish a medical home and to determine the success, continued need and feasibility of expanding such a program and allowing similar programs to operate on a statewide basis.~~

~~(b) In carrying out this pilot program, it is the intent of the Legislature to eliminate legal, statutory and regulatory barriers to the establishment of pilot programs providing preventive and primary care services for a prepaid fee; to encourage residents of this state to establish and use a medical home; to expand preventive and primary care services for the uninsured; and to exempt health providers participating in the pilot program from regulation as an insurer, the operation of insurance laws of the state and all other laws inconsistent with the purposes of this article.~~

~~§16-2J-2. Definitions.~~

~~For the purposes of this article, the following definitions apply:~~

~~(1) "Dependent" has the same meaning set forth in subsection (d), section one-a, article sixteen, chapter thirty-three of this code;~~

~~(2) "Family" means a subscriber and his or her dependents;(3) "Medical home" means a team approach to providing health care and care management. Whether involving a primary care provider, specialist or sub-specialist, care management includes the development of a plan of care, the determination of the outcomes desired, facilitation and navigation of the health care system, provision of follow-up and support for achieving the identified outcomes. The medical home maintains a centralized, comprehensive record of all health related services to provide continuity of care;~~

~~(4) "Participating provider" means a provider under this article that has been granted a~~

~~license under this article to operate as part of the pilot program;~~

~~(5) "Primary care" means basic or general health care which emphasizes the point when the patient first seeks assistance from the medical care system and the care of the simpler and more common illnesses;~~

~~(6) "Provider" has the same meaning as "ambulatory health care facility" set forth in subsection (b), section two, article two-d of this chapter or "private office practice" as set forth in subsection (a)(1), section four of said article;~~

~~(7) "Qualifying event" means loss of coverage due to: (i) Emancipation and resultant loss of coverage under a parent or guardian's plan; (ii) divorce and loss of coverage under the former spouse's plan; (iii) termination of employment and resultant loss of coverage under an employer group plan: *Provided,* That any rights of coverage under a COBRA continuation plan as that term is defined in section three-m, article sixteen, chapter thirty-three of this code, shall not be considered coverage under an employer group health plan; (iv) involuntary termination of coverage under a group health benefit plan except for termination due to nonpayment of premiums or fraud by the insured; or (v) exhaustion of COBRA benefits;~~

~~(8) "Subscriber" means any individual who subscribes to a prepaid program approved and operated in accordance with the provisions of this article, including an employee of any employer that has purchased a group enrollment on behalf of its employees.~~

~~§16-2J-3. Authorization of preventive care pilot program; number of participants and sites; Health Care Authority considerations in selection of participating providers; funding.~~

~~(a) (1) The Health Care Authority shall, in consultation with the Insurance Commissioner, develop and implement during the fiscal year beginning July 1, 2006, a pilot program that permits providers to market and sell prepaid memberships entitling subscribers to obtain preventive and primary health care from the participating providers.~~

~~(2) Participating providers shall not be allowed to offer their qualifying services at more than six separate sites.~~

~~(3) The pilot program shall expire on June 30, 2016.~~

~~(4) Those providers participating in the pilot program as of its expiration date may continue to operate pursuant to this article.~~

~~(5) The Health Care Authority shall report to the Legislative Oversight Commission on Health and Human Resources Accountability on the pilot program by December 1, 2015.~~

~~(b) Subject to this article, the Health Care Authority is vested with discretion to select providers using diversity in practice organization, geographical diversity and other criteria it deems appropriate. The Health Care Authority also shall give consideration to providers located in rural areas or serving a high percentage or large numbers of uninsured.~~

~~(c) In furtherance of the objectives of this article, the Health Care Authority is authorized to accept any and all gifts, grants and matching funds whether in the form of money or services. However, no gifts, grants and matching funds shall be provided to the Health Care Authority by the State of West Virginia to further the objectives of this article.~~

~~§16-2J-4. License for preventive care pilot program.~~

~~(a) No provider may participate in the pilot program without first obtaining a preventive care pilot program license from the Health Care Authority.~~

~~(b) The Health Care Authority shall determine the eligibility of providers to obtain licenses on the basis of applications filed by providers on forms developed by the Health Care Authority.~~

~~(c) Upon approval of the application, the participating provider shall be granted a license to market and sell prepaid health services under such terms as may be established in guidelines developed by the Health Care Authority and the Insurance Commissioner.~~

~~§16-2J-5. Insurance Commissioner approval of fees, marketing materials and forms and certification of financial condition; statement of services.~~

~~(a) The Insurance Commissioner shall develop guidelines for all forms, marketing~~

~~materials and fees proposed by program applicants and participating providers under the same criteria generally applicable to accident and sickness insurance policies.~~

~~(b) All fees, marketing materials and forms proposed to be used by any program applicant or participating provider are subject to prior approval of the Insurance Commissioner, which the Insurance Commissioner shall communicate to the Health Care Authority. Fees may not be excessive, inadequate, or unfairly discriminatory.~~

~~(c) The Insurance Commissioner must certify whether a program applicant or, upon the request of the Health Care Authority, an already participating provider is in a sound financial condition and capable of operating in a manner that is not hazardous to its prospective subscribers or the people of West Virginia.~~

~~(d) Every subscriber is entitled to evidence of program membership that shall contain a clear, concise and complete statement of the services provided by the participating provider and the benefits, if any, to which the subscriber is entitled; any exclusions or limitations on the service, kind of service, benefits, or kind of benefits, to be provided, including any copayments; and where and in what manner information is available as to how a service may be obtained.~~

~~(e) Fees paid to participating providers are not subject to premium taxes and surcharges imposed on insurance companies.~~

~~(f) Notwithstanding the provisions of chapter thirty-three of this code to the contrary, participation by providers in the preventive care clinic-based pilot program created and authorized pursuant to this article is not to be considered as providing insurance or as offering insurance services. Such providers and services are specifically excluded from the definitions of "insurer" and "insurance" as defined in article one, chapter thirty-three of this code, and are not subject to regulation by the Insurance Commissioner except to the extent set forth in this article, nor are participating providers unauthorized insurers pursuant to section four, article forty-four of chapter thirty-three of this code.~~

~~§16-2J-6. Rule-making authority.~~

~~The Health Care Authority and the Insurance Commissioner shall promulgate joint rules as necessary to implement the provisions of this article, including emergency rules, promulgated pursuant to, chapter twenty-nine-a of this code.~~

~~§16-2J-7. Participating provider plan requirements; primary care services; prior coverage restrictions; notice of discontinuance or reduction of benefits.~~

~~In addition to this article and any guidelines established by the Health Care Authority and Insurance Commissioner, the plans offered pursuant to this article shall be subject to the following:~~

~~(1) Each participating provider and site must offer a minimum set of preventive and primary care services as established by the Health Care Authority.~~

~~(2) No participating provider may offer: (i) An individual plan to any individual who currently has a health benefit plan or who was covered by a health benefit plan within the preceding twelve months unless said coverage was lost due to a qualifying event; (ii) a family plan to any family that includes an adult to be covered who currently has a health benefit plan or who was covered by a health benefit plan within the preceding twelve months unless said coverage was lost due to a qualifying event; or (iii) an employee group plan to any employer that currently has a group health benefit plan or had a group health benefit plan covering its employees within the preceding twelve months; (iv) Notwithstanding the provisions of (i), (ii) or (iii) of this subsection, a participating provider may offer a plan to an individual if the individual is covered by a high deductible health benefit plan or policy and a participating provider may offer a plan to an employer group if the employer group is covered by a high deductible health benefit plan or policy. The participating provider shall give the perspective individual or employer a notice that indicates that the payment for the prepaid services may not count towards a health benefit plan deductible and that credit towards the deductible will depend on the health benefit policy or certificate language. The Insurance Commissioner shall approve the form of the notice to be used by the provider. For the purpose of this section, "high deductible health benefit plan" means a health

~~benefit plan with a minimum individual annual deductible of $3,000 or, if applicable, a family annual deductible of $3,000. Any employer who has converted its health benefit plan from a low deductible plan to a high deductible health benefits plan may not purchase a plan from a participating provider for six months from the date of conversion. Any individual who has converted his or her health benefit policy from a low deductible health policy to a high deductible plan may not purchase a plan from a participating provider for three months from date of conversion.~~

~~(3) On or before July 1, 2009, the Health Care Authority and the Insurance Commissioner shall propose a rule for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code, to permit participation by a subscriber or employer with a comprehensive high deductible plan if the subscriber or employer is able to demonstrate that the participation will not negatively impact the coverage that is currently offered or will be offered by the employer. The rule shall provide for notice to the subscriber or employer that the payment for the prepaid services may or may not count towards the health insurance deductible, the determination of which will depend on the health insurance policy language.~~

~~(4) A participating provider must provide subscribers and, where applicable, subscribers' employers with a minimum of thirty days' notice of discontinuance or reduction of subscriber benefits.~~

~~§16-2J-8. Guidelines for evaluation of the pilot program; report to Legislative Oversight Commission on Health and Human Resources Accountability.~~

~~(a) The Health Care Authority shall establish by guidelines criteria to evaluate the pilot program and may require participating providers to submit such data and other information related to the pilot program as may be required by the Health Care Authority: *Provided,* That all personal income tax returns filed pursuant to this article shall be treated as confidential pursuant to the provisions of section five-d, article ten, chapter eleven of this code. For purposes of this article, this information shall be exempt from disclosure under the freedom of information act in article~~

~~one, chapter twenty-nine-b of this code.~~

~~(b) No later than December 1, 2007 and annually thereafter during the operation of the pilot program, the Health Care Authority must submit a report to the Legislative Oversight Commission of Health and Human Resources Accountability as established in article twenty-nine-e of this chapter on progress made by the pilot project including suggested legislation, necessary changes to the pilot program and suggested expansion of the pilot program.~~

~~§16-2J-9. Grounds for refusal to renew; revocation and suspension of pilot program license; penalties; termination of suspension, reissuance and renewal of license.~~

~~(a) The Health Care Authority may after notice and hearing refuse to renew, or may revoke or suspend the license of a participating provider, in addition to other grounds therefor in this article, if the participating provider:~~

~~(1) Violates any provision of this article;~~

~~(2) Fails to comply with any lawful rule or order of the Health Care Authority;~~

~~(3) Is operating in an illegal, improper or unjust manner;~~

~~(4) Is found by the Insurance Commissioner to be in an unsound condition or in such condition as to render its further operation in West Virginia hazardous to its subscribers or to the people of West Virginia;~~

~~(5) Compels subscribers under its contract to accept less service than due them or to bring suit against it to secure full service when it has no substantial defense;~~

~~(6) Refuses to be examined or to produce its accounts, records and files for examination by the Insurance Commissioner when requested to do so pursuant to section five of this article;~~

~~(7) Fails to pay any final judgment rendered against it in West Virginia within thirty days after the judgment became final or time for appeal expired, whichever is later;~~

~~(8) Fails to pay when due to the State of West Virginia any taxes, fees, charges or penalties.~~

~~(b) In addition to or in lieu of refusing to renew, revoking or suspending the license of a~~

~~participating provider in any case, the Health Care Authority may, by order, require the participating provider to pay to the State of West Virginia a penalty in a sum not exceeding $5,000 for each violation. Upon the failure of the provider to pay such penalty within thirty days after notice thereof, the Health Care Authority shall revoke or suspend the license of such participating provider.~~

~~(c) When any license has been revoked or suspended or renewal thereof refused, the Health Care Authority may reissue, terminate the suspension of or renew such license when it is determined that the conditions causing such revocation, suspension or refusal to renew have ceased to exist and are unlikely to recur.~~

ARTICLE 3F. DIRECT PRIMARY CARE PRACTICE.

§30-3F-1. Definitions.

As used in this section:

(1) "Boards" means the West Virginia Board of Medicine; the West Virginia Board of Osteopathic Medicine, the West Virginia Board of Optometry, West Virginia Board of Chiropractic, West Virginia Board of Dentistry and the West Virginia Board of Examiners for Registered Professional Nurses;

(2) "Direct primary care membership agreement" means a written contractual agreement between a primary care provider and a person, or the person's legal representative;

(3) "Direct primary care provider" means an individual or legal entity, alone or with others professionally associated with the provider or other legal entity, that is authorized to provide primary care services and who chooses to enter into a direct primary care membership agreement;

(4) "Medical products" means any product used to diagnose or manage a disease, including any medical device, treatment or drug;

(5) "Medical services" means a screen, assessment, diagnosis or treatment for the purpose of promotion of health or the detection and management of disease or injury within the

competency and training of the direct primary care provider; and

(6) “Primary care provider” means an individual or other legal entity that is authorized to provide medical services and medical products under his or her scope of practice in this state.

§30-3F-2. Direct Primary Care.

(a) A person or a legal representative of a person may seek care outside of an insurance plan, or outside of the Medicaid or Medicare program, and pay for the care.

(b) A primary care provider may accept payment for medical services or medical products outside of an insurance plan.

(c) A primary care provider may accept payment for medical services or medical products provided to a Medicaid or Medicare beneficiary.

(d) A patient or legal representative does not forfeit insurance benefits, Medicaid benefits or Medicare benefits by purchasing medical services or medical products outside the system.

(e) The offer and provision of medical services or medical products purchased and provided under this article is not an offer of insurance nor regulated by the insurance laws of the state.

(f) The direct primary care provider may not bill third parties on a fee for service basis for services provided under the direct primary care membership agreement.

(g) A primary care provider may not bill any third-party payer for services rendered or products sold pursuant to a direct primary care membership agreement.

§30-3F-3. Prohibited and authorized practices.

(a) A direct primary care membership agreement is not insurance and is not subject to regulation by the Office of the Insurance Commission.

(b) A direct primary care provider or its agent is not required to obtain a certification of authority or license under chapter thirty-three to market, sell or offer to sell a direct primary care agreement.

(c) A direct primary care membership agreement is not a discount medical plan.

(d) A direct primary care membership agreement shall:

(1) Be in writing;

(2) Be signed by the primary care provider or agent of the primary care provider and the individual patient or his or her legal representative;

(3) Allow either party to terminate the agreement on at least 30 days prior written notice to the other party;

(4) Describe the scope of primary care services that are covered by the periodic fee;

(5) Specify the periodic fee and any additional fees outside of the periodic fee for ongoing care under the agreement;

(6) Specify the duration of the agreement and any automatic renewal periods. Any per-visit charges under the agreement will be less than the monthly equivalent of the periodic fee. The person is not required to pay more than twelve months of the fee in advance. Funds are not earned by the practice until the month of ongoing care is completed. Upon discontinuing the agreement all unearned funds are returned to the patient; and

(7) Prominently state in writing that the agreement is not health insurance.

§30-3F-4. Rules.

The boards may propose rules for legislative approval in accordance with article three, chapter twenty-nine-a of this code, to effectuate the provisions of this article.

§30-3F-5. Violations.

Violations of this article constitute unprofessional conduct and may subject violators to sanctions which may be pursued by the boards.

NOTE: The purpose of this bill is to permit individuals to enter into agreements, for direct primary care with an individual or other legal entity authorized to provide primary care services, outside of an insurance plan or outside of the Medicaid or Medicare program and pay for the care. The bill provides that a direct primary care membership agreement is not considered insurance and that a direct primary care provider is not required to obtain certain credentials or licensing. The bill prohibits the billing of third party providers for direct primary care services. It details requirements for a direct primary care membership agreement. The bill permits rule-making authority by the West Virginia Board of Medicine;

the West Virginia Board of Osteopathic Medicine and the West Virginia Board of Examiners for Registered Professional Nurses to effectuate the provisions of this new article. And the bill authorizes civil penalties in the form of sanctions by the respective boards for violations that constitute unprofessional conduct.

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