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House Bill 2005

FISCAL NOTE

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[Introduced February 10, 2021; 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 section, designated §16-29B-6; to amend said code by adding thereto a new article, designated §33-60-1, §33-60-2, §33-60-3, §33-60-4, §33-60-5, §33-60-6, §33-60-7, §33-60-8, and §33-60-9; to amend said code by adding thereto a new article, designated §33-61-1, and §33-61-2; and to amend said code by adding thereto a new article, designated §47-29-1, all relating to health care costs generally; providing a review process by the Attorney General's office for nonprofit hospitals; providing for the regulation of out-of-state healthcare providers and non- network facility based providers; providing for the disclosures of a healthcare facility and the publication of a carrier's network; defining the responsibilities of a carrier inadvertent to out-of-state network services; providing for binding arbitration in the event of payment disputes; providing for healthcare savings cost calculations, violations and legislative rules; providing for price transparency and a publication of prices; and providing a cost of healthcare appointment prices.

Be it enacted by the Legislature of West Virginia:

CHAPTER 16. PUBLIC HEALTH.

ARTICLE 29B. HEALTH CARE AUTHORITY.

§16-29B-6. Review of nonprofit status of hospitals.

(a) A hospital's nonprofit status shall be reviewed annually by the Attorney General to ensure a nonprofit hospital is fulfilling its mission to serve its community. The standard shall be developed by the Health Care Authority.

(b) A summary of every contract or an amendment to an existing contract for the payment of patient care services between a purchaser or third party payor and a hospital shall be filed by the hospital to the health care authority.

CHAPTER 33. INSURANCE.

ARTICLE 60. OUT-OF-NETWORK CONSUMER PROTECTION, TRANSPARENCY,

COST CONTAINMENT AND ACCOUNTABILITY ACT.

§33-60-1. Definitions.

As used in this article:

"Ambulatory surgical facility" means the same as defined in §16-5B-1 of this code.

"Carrier means" an entity 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 benefits plan, including: an insurance company authorized to issue health benefits plans; a health maintenance organization; a health, hospital, or medical service corporation; a multiple employer welfare arrangement; the Public Employees Insurance Benefits Program; or any other entity providing a health benefits plan. Except as provided under the provisions of this article, "carrier" shall not include any other entity providing or administering a self-funded health benefits plan.

"Commissioner" means the Commissioner of the Offices of the Insurance Commissioner.

"Covered person" means a person on whose behalf a carrier is obligated to pay health care expense benefits or provide health care services.

"Emergency or urgent basis" means all emergency and urgent care services.

"Facility-based provider" means a physician or provider who provides health care services to patients of a health care facility.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this state by or through a carrier. For the purposes of this article, "health benefits plan" shall not include the following plans, policies or contracts: Medicaid, Medicare, Medicare Advantage, accident only, credit, disability, long-term care, TRICARE supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued; a dental plan; and hospital confinement indemnity coverage.

"Health care facility" means a hospital, an ambulatory surgery facility, or any other free-standing ambulatory care center.

"Health care professional" means an individual, acting within the scope of his or her licensure, certification or registration, who provides a covered service in a health benefits plan.

"Health care provider" or "provider" means a health care professional or health care facility.

"Hospital" means a facility licensed pursuant to §16-5B-1 *et seq*. of this code and any acute-care facility operated by the state government that primarily provides inpatient diagnostic, treatment or rehabilitative services to injured, disabled or sick persons under the supervision of physicians and includes psychiatric hospitals.

"Inadvertent out-of-network services" means health care services that are: covered under a health benefits plan that provides a network; and provided by an out-of-network health care provider in the event that a covered person utilizes an in-network health care facility for covered health care services and, for any reason, in-network health care services are unavailable in that facility. "Inadvertent out-of-network services" shall include laboratory testing ordered by an in-network health care provider and performed by an out-of-network bio-analytical laboratory.

"Knowingly, voluntarily, and specifically selected an out-of-network provider" means that a covered person chose the services of a specific provider, with full knowledge that the provider is out-of-network with respect to the covered person's health benefits plan, under circumstances that indicate that covered person had the opportunity to be serviced by an in-network provider, but instead selected the out-of-network provider. Disclosure by a provider of network status shall not render a covered person's decision to proceed with treatment from that provider a choice made "knowingly" pursuant to this definition.

"Medical necessity" or "medically necessary" means or describes a health care service that a health care provider, exercising his or her prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the covered person's illness, injury, or disease; not primarily for the

convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury, or disease.

"Medicare" means the federal Medicare program established pursuant to Pub.L.89-97 (42 U.S.C. s.1395 *et seq.*).

"Office" means the Office of the Insurance Commissioner.

"Self-funded health benefits plan" or "self-funded plan" means a self-insured health benefits plan governed by the provisions of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. s.1001 *et seq*.

§33-60-2. Non-Network Facility-Based Providers

(a) Except as provided by subsection (c), a carrier shall pay for a covered health care service provided by a non-network physician or provider who is a facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the services at a health care facility that is a network provider. The carrier shall make a payment required by this subsection directly to the physician or provider not later than, as applicable:

(1) The 30th day after the date the carrier receives a clean electronic claim for those services that includes all information necessary for the carrier to pay the claim; or

(2) The 45th day after the date the carrier receives a clean nonelectronic claim for those services that includes all information necessary for the carrier to pay the claim.

(b) Except as provided by subsection (c), a non-network facility-based provider, or a person asserting a claim as an agent or assignee of the provider, may not bill an enrollee receiving a health care service described by subsection (a) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's health care plan that:

(1) Is based on:

(A) The amount initially determined payable by the carrier; or

(B) If applicable, a modified amount as determined under the carrier's internal appeal process; and

(2) Is not based on any additional amount determined to be owed to the provider under this article.

(c) This section does not apply to a nonemergency health care or medical service:

(1) That an enrollee elects to receive in writing in advance of the service with respect to each non-network physician or provider providing the services; and

(2) For which a non-network physician or provider, before providing the service, provides a complete written and verbal disclosure to the enrollee that:

(A) Explains that the physician or provider does not have a contract with the enrollee's health benefit plan;

(B) Discloses projected amounts for which the enrollee may be responsible; and

(C) Discloses the circumstances under which the enrollee would be responsible for these amounts.

§33-60-3. Disclosures by health care facility.

(a) A health care facility shall post on the facility's website:

(1) The health benefits plans in which the facility is a participating provider;

(2) A statement that:

(A) Physician services provided in the facility are not included in the facility's charges;

(B) Physicians who provide services in the facility may or may not participate with the same health benefits plans as the facility;

(C)The covered person should check with the physician arranging for the facility services to determine the health benefits plans in which the physician participates; and

(D) The covered person should contact their carrier for further consultation on those costs;

(3) As applicable, the name, mailing address, and telephone number of the hospital-based

physician groups that the facility has contracted with to provide services including, but not limited to, anesthesiology, pathology, and radiology; and

(4) As applicable, the name, mailing address, and telephone number of physicians employed by the facility and whose services may be provided at the facility, and the health benefits plans in which they participate.

(b) If, between the time the notice required is provided to the covered person and the time the procedure takes place, the network status of the facility changes as it relates to the covered person's health benefits plan, the facility shall notify the covered person promptly.

(c) The Office of the Insurance Commissioner shall specify in further detail the content and design of the disclosure form and the manner in which the form shall be provided.

§33-60-4. Publication of a carrier's network.

(a) A carrier shall update its website within 20 days of the addition or termination of a provider from the carrier's network or a change in a physician's affiliation with a facility, provided that in the case of a change in affiliation the carrier has had notice of such change.

(b) With respect to out-of-network services, for each health benefits plan offered, a carrier shall provide a covered person with:

(1) A clear description of the plan's out-of-network health care benefits, including the methodology used by the entity to determine the allowed amount for out-of-network services;

(2) The allowed amount the plan will reimburse under that methodology and, in situations in which a covered person requests allowed amounts associated with a specific Current Procedural Terminology code, the portion of the allowed amount the plan will reimburse and the portion of the allowed amount that the covered person will pay, including an explanation that the covered person will be required to pay the difference between the allowed amount as defined by the carrier's plan and the charges billed by an out-of-network provider;

(3) Examples of anticipated out-of-pocket costs for frequently billed out-of-network services;

(4) Information in writing and through an internet website that reasonably permits a covered person or prospective covered person to calculate the anticipated out-of-pocket cost for out-of-network services in a geographical region or zip code based upon the difference between the amount the carrier will reimburse for out-of-network services and the usual and customary cost of out-of-network services;

(5) Information in response to a covered person's request, concerning whether a health care provider is an in-network provider;

(6) Other information as the commissioner determines appropriate and necessary to ensure that a covered person receives sufficient information necessary to estimate their out-of-pocket cost for an out-of-network service and make a well-informed health care decision; and

(7) Access to a telephone hotline for consumers to call with questions about network status and out-of-pocket costs.

(c) If a carrier authorizes a covered health care service to be performed by an in-network health care provider with respect to any health benefits plan, and the provider status changes to out-of-network before the authorized service is performed, the carrier shall notify the covered person that the provider is no longer in-network as soon as practicable. If the carrier fails to provide the notice at least 30 days prior to the authorized service being performed, the covered person's financial responsibility shall be limited to the financial responsibility the covered person would have incurred had the provider been in-network with respect to the covered person's health benefits plan.

(d) A carrier shall incorporate into the Explanation of Benefits, and all reimbursement correspondence to the consumer and the provider, clear and concise notification that inadvertent and involuntary out-of-network charges are not subject to balance billing above and beyond the financial responsibility incurred under the terms of the contract for in-network service. Any attempt by the provider to collect, bill, or invoice funds should be promptly reported to the carrier's customer service division at the phone number that the carrier shall provide on the Explanation

of Benefits and all reimbursement correspondence to the consumer.

(e) A carrier shall include in the carrier's annual public regulatory filings, the number of claims submitted by health care providers to the carrier which are denied or down coded by the carrier and the reason for the denial or down coding determination.

§33-60-5. Responsibilities of carrier relative to inadvertent out-of-network services.

(a) With respect to a carrier, if a covered person receives inadvertent out-of-network services, or services at an in-network or out-of-network health care facility on an emergency or urgent basis, the carrier shall ensure that the covered person incurs no greater out-of-pocket costs than the covered person would have incurred with an in-network health care provider for covered services. The out-of-network provider shall not bill the covered person, except for applicable deductible, copayment, or coinsurance amounts that would apply if the covered person utilized an in-network health care provider for the covered services.

(b) (1) With respect to inadvertent out-of-network services, or services at an in-network or out-of-network health care facility on an emergency or urgent basis, benefits provided by a carrier that the covered person receives for health care services shall be assigned to the out-of-network health care provider, which shall require no action on the part of the covered person. Once the benefit is assigned as provided in this subsection:

(A) Any reimbursement paid by the carrier shall be paid directly to the out-of-network provider; and

(B) The carrier shall provide the out-of-network provider with a written remittance of payment that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance amounts owed by the covered person.

(c) If inadvertent out-of-network services or services provided at an in-network or out-of-network health care facility on an emergency or urgent basis are performed in accordance with subsection (a) of this section, the out-of-network provider may bill the carrier for the services rendered. The carrier may pay the billed amount or the carrier shall determine within 20 days from

the date of the receipt of the claim for the services whether the carrier considers the claim to be excessive, and if so, the carrier shall notify the provider of this determination within 20 days of the receipt of the claim. If the carrier provides this notification, the carrier and the provider shall have 30 days from the date of this notification to negotiate a settlement. The carrier may attempt to negotiate a final reimbursement amount with the out-of-network health care provider which differs from the amount paid by the carrier pursuant to this subsection. If there is no settlement reached after the 30 days, the carrier shall pay the provider their final offer for the services. If the carrier and provider cannot agree on the final offer as a reimbursement rate for these services, the carrier or provider shall initiate binding arbitration within 30 days of the final offer.

§33-60-6. Payment disputes, binding arbitration.

If attempts to negotiate reimbursement for services provided by an out-of-network health care provider do not result in a resolution of the payment dispute, and the difference between the carrier's and the provider's or facility's final offers is not less than $1,000, the carrier or out-of-network health care provider shall initiate binding arbitration to determine payment for the services.

§33-60-7. Notice of protections provided.

(a) A carrier shall provide a written notice, in a form and manner to be prescribed by the commissioner, to each covered person of the protections provided to covered persons pursuant to this article. The notice shall include information on how a consumer can contact the office to report and dispute an out-of-network charge. The notice required pursuant to this section shall be posted on the carrier's website.

(b) The commissioner shall provide a notice on the office's website containing information for consumers relating to the protections provided by this article, information on how consumers can report and file complaints with the office relating to any out-of-network charges, and information and guidance for consumers regarding arbitrations.

§33-60-8. Calculation of savings; reports.

A carrier shall calculate, as part of rate filings required to be filed under West Virginia law, the savings that result from a reduction in out-of-network claims payments pursuant to the provisions of this article. The office shall include that information in the information provided on the office's website.

§33-60-9. Violations, inducements.

(a) It shall be a violation of this article if an out-of-network health care provider, directly or indirectly related to a claim, knowingly waives, rebates, gives, pays, or offers to waive, rebate, give or pay all or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek health care services from that provider. As the commissioner shall prescribe by legislative rule, a pattern of waiving, rebating, giving or paying all or part of the deductible, copayment or coinsurance by a provider shall be considered an inducement for the purposes of this subsection.

(b) This section shall not apply to any waiver, rebate, gift, payment, or offer that falls within a safe harbor under federal laws related to fraud and abuse concerning patient cost-sharing, including, but not limited to, anti-kickback, self-referral, false claims, and civil monetary penalties, including any advisory opinions issued by the Centers for Medicare and Medicaid Services or the Office of Inspector General pertaining to those laws.

§33-60-10. Legislative Rules.

The Commissioner of Insurance may adopt legislative rules in order to effectuate the purposes of this article.

ARTICLE 61. PRICE TRANSPARENCY.

§33-61-1. Definitions.

As used in this article, the term:

(1) "Covered person" means an individual who is covered under a health benefit policy.

(2) "Emergency services" means those health care services that are provided for a

condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

(A) Placing the patient's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(3) "Health benefit policy" or "policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed in this state, including, but not limited to, those contracts executed by the state on behalf of state employees under §5-16-1 *et seq* of this code.

(4) "Health care provider" or "provider" means any physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advanced practice nurse, registered optician, licensed professional counselor, physical therapist, marriage and family therapist, chiropractor, athletic trainer, occupational therapist, speech language pathologist, audiologist, dietitian, or physician assistant qualified pursuant to §30-1-1 *et seq* of this code.

(5) "Health care service" means:

(A) Physical and occupational therapy services;

(B) Obstetrical and gynecological services;

(C) Radiology and imaging services;

(D) Laboratory services;

(E) Infusion therapy;

(F) Inpatient or outpatient surgical procedures;

(G) Outpatient nonsurgical diagnostic tests or procedures; and

(H) Any services designated by the commissioner as shoppable by health care consumers.

(6) “Hierarchical Condition Category Methodology” means a coding system designed by the Centers for Medicare and Medicaid Services to estimate future health care costs for patients.

(7) “Insurer” means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, preferred provider organization, provider sponsored heath care corporation, managed care entity, or any similar entity authorized to issue contracts under this title or to provide health benefit policies.

§33-61-2. Publication of prices.

(a) An insurer subject to §33-15-1 *et seq.*, §33-16-1 *et seq.*, §33-24-1 *et seq.*, §33-25-1 *et seq.*, §33-25A-1 *et seq.*, and PEIA shall make available on its publicly accessible website an interactive mechanism whereby any member of the public may:

(1) For each health benefit policy offered, compare the payment amounts accepted by in-network providers from such insurer for the provision of a particular health care service within the previous year;

(2) For each health benefit policy offered, obtain an estimate of the average amount accepted by in-network providers from such insurer for the provision of a particular health care service within the previous year;

(3) For each health benefit policy offered, obtain an estimate of the out-of-pocket costs that such covered person would owe his or her provider following the provision of a particular health care service;

(4) Compare quality metrics applicable to in-network providers for major diagnostic categories with adjustments by risk and severity based upon the Hierarchical Condition Category Methodology or a nationally recognized health care quality reporting standard designated by the commissioner. Metrics shall be based on reasonably universal and uniform data bases with sufficient claim volume. If applicable to the provider, quality metrics shall include, but not be limited to:

(A) Risk adjusted and absolute hospital readmission rates;

(B) Risk adjusted and absolute hospitalization rates;

(C) Admission volume;

(D) Utilization volume;

(E) Risk adjusted rates of adverse events; and

(F) Risk adjusted and absolute relative total cost of care.

(5) Access any all-payer health claims data base which may be maintained by the department.

(b) An insurer subject to §33-15-1 *et seq.*, §33-16-1 *et seq.*, §33-24-1 *et seq.*, §33-25-1 *et seq.*, §33-25A-1 *et seq.*, and PEIA shall provide notification on its website that the actual amount that a covered person will be responsible to pay following the receipt of a particular health care service may vary due to unforseen costs that arise during the provision of such service.

(c) Each estimate of out-of-pocket costs shall provide the following:

(1) The out-of-pocket costs a covered person may owe if he or she has exceeded his or her deductible; and

(2) The out-of-pocket costs a covered person may owe if he or she has not exceeded his or her deductible.

(d) An insurer subject to §33-15-1 *et seq.*, §33-16-1 *et seq.*, §33-24-1 *et seq.*, §33-25-1 *et seq.*, §33-25A-1 *et seq.*, and PEIA may contract with a third party to satisfy part or all of the requirements of this section.

(e) Nothing in this section shall prohibit an insurer from charging a covered person cost sharing beyond that included in the estimate provided, if such additional cost sharing resulted from the unforseen provision of additional health care services and the cost-sharing requirements of such unforseen health care services were disclosed in such covered person's policy or certificate of insurance.

CHAPTER 47. REGULATION OF TRADE.

ARTICLE 29. HEALTH CARE SERVICES.

§47-29-1. Prices of health care services.

(a) When making an appointment to receive health care services, a patient shall receive the cost estimate as provided in §33-61-1 *et seq*. of this code.

(b) A health care facility may not charge a facility fee.

NOTE: The purpose of this bill is to provide more transparent healthcare costs to West Virginians, and in doing so provide a review process by the Attorney General's office for nonprofit hospitals, regulate out-of-state healthcare providers and non-network facility based providers, list disclosures of a healthcare facility and publication of a carrier's network, further define the responsibilities of a carrier inadvertent to out of state network services, provide binding arbitration for payment disputes, healthcare savings cost calculations, violations and legislative rules, provide for price transparency and a publication of prices, and provide the cost of healthcare appointment prices.

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