ENGROSSED

COMMITTEE SUBSTITUTE

FOR

H. B. 2960

(BY DELEGATE(S) 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.

1 As used in this article:

2 (1) "Adverse determination" means a decision by or on

3 behalf of an issuer to:

4 (A) Rescind coverage;

5 (B) Declare an individual not eligible to participate in the

6 health benefit plan; or

7 (C) Deny, reduce or terminate payment for a benefit, or fail

8 to make payment, in whole or in part, for a benefit, based on a

9 determination that:

10 (i) The benefit is not covered; or

11 (ii) The benefit is experimental, investigational or does not

12 meet the issuer's requirements for medical necessity,

13 appropriateness, health care setting, level of care or

14 effectiveness.

15 (2) “External review” means a review of an adverse
16 determination by an independent review organization.
17 (3) “Final adverse determination” means an adverse
18 determination that has been upheld by the issuer at the
19 completion of the internal grievance procedures or an adverse
20 determination with respect to which the internal grievance
21 procedures have been deemed exhausted.
22 (4) “Health plan issuer” or “issuer” means an entity required
23 to be licensed under this chapter that contracts, or offers to
24 contract to provide, deliver, arrange for, pay for, or reimburse
25 any of the costs of health care services under a health benefit
26 plan, including an accident and sickness insurance company, a
27 health maintenance corporation, a health care corporation, a
28 health or hospital service corporation, and a fraternal benefit
29 society.
30 (5) “Health benefit plan” means a policy, contract, certificate
31 or agreement entered into, offered or issued by an issuer to
32 provide, deliver, arrange for, pay for, or reimburse any of the
33 costs of health care services, including short-term and
34 catastrophic health insurance policies and policies that pay on a

35 cost-incurred basis, but excludes the excepted benefits defined
36 in 42 U.S.C. §300gg-91 and policies, contracts, certificates or
37 agreements excluded by rules promulgated pursuant to section
38 four of this article.
39 (6) "Independent review organization" means an entity
40 approved by the commissioner to conduct external reviews of
41 final adverse determinations.
42 (7) "Utilization review" means a system for the evaluation
43 of the necessity, appropriateness and efficiency of the use of
44 health care services, procedure and facilities.
45 (8) "Rescission" means a discontinuance of coverage under
46 a health benefit plan that has a retroactive effect or a
47 cancellation. The term does not include a cancellation or
48 discontinuation that is attributable to a failure to timely pay
49 required premiums or contributions towards the cost of coverage.

§33-16H-2. Issuer requirements.

1 An issuer shall, in accordance with rules promulgated
2 pursuant to section four of this article, develop processes for
3 utilization review and internal grievance procedures and shall
4 make external review available with respect to all adverse
5 determinations.

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

1 (a) An individual or issuer may seek judicial review of a
2 final decision rendered by an independent review organization
3 by filing a petition in the circuit court of the county in which the
4 individual resides, within sixty days after he or she receives
5 notice of the decision. The issuer shall provide any service or
6 pay any claim determined in a final administrative decision to be
7 covered and medically necessary for the case under review
8 during any period of judicial review until judicial review is
9 complete and final, including any appeal. However, if the issuer
10 initiates the appeal and the individual prevails in such appeal
11 then the issuer shall be responsible for the reasonable attorneys
12 fees of the individual.
13 (b) This article does not create any new cause of action or
14 eliminate any presently existing cause of action.
15 (c) If an issuer seeks judicial review of a final decision, the
16 issuer must file the petition in the circuit court of the county in
17 which the individual resides.

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

1 (a) The commissioner shall promulgate emergency rules and,
2 in accordance with the provisions of article three, chapter

3 twenty-nine-a of this code, shall propose legislative rules for
4 approval by the Legislature, to implement the provisions of this
5 article, including, but not limited to, rules to:
6 (1) Define the scope of the applicability of this article;
7 (2) Establish requirements for all issuers with regard to
8 utilization review and for internal grievance procedures and
9 external review of adverse determinations, which rules shall be
10 based on the corresponding model acts adopted by the National
11 Association of Insurance Commissioners and, with respect to
12 external review, shall meet or exceed the minimum consumer
13 protections established by the federal Patient Protection and
14 Affordable Care Act (Public Law 111-148), as amended by the
15 federal Health Care and Education Reconciliation Act of 2010
16 (Public Law 111-152); and
17 (3) Provide for judicial review pursuant to subsection (b),
18 section three of this article, which rules shall be based on the
19 provisions of this code and rules governing judicial review of
20 contested cases under the state administrative procedures act.
21 (b) Notwithstanding the provisions of section one, article
22 twenty-three of this chapter; section four, article twenty-four of

23 this chapter; section six, article twenty-five of this chapter; and
24 section twenty-four, article twenty-five-a of this chapter, this
25 article and the rules promulgated under this article are applicable
26 to all health benefits plans and supersede any provisions to the
27 contrary in this chapter or in any rules promulgated under this
28 chapter.