Senate Bill No. 366

(By Senators Ferns, Stollings, Walters and D. Hall)

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[Introduced January 29, 2015; referred to the Committee on Banking and Insurance; and then to the Committee on Finance.]

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A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §33-50-l, §33-50-2, §33-50-3 and §33-50-4, all relating to the West Virginia Health Benefit Exchange; establishing patient protections; and providing public disclosures.

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 §33-50-l, §33-50-2, §33-50-3 and §33-50-4, all to read as follows:

ARTICLE 50. PATIENT PROTECTION AND TRANSPARENCY ACT.

§33-50-l. Definitions.

For the purposes of this article, the following words and terms mean the following:

(1) "Commissioner" means the West Virginia Insurance Commissioner.

(2) "Consumer" means an individual or family purchasing insurance coverage through the exchange.

(3) "Discriminatory practice" means the exclusion from or failure or refusal to extend to any consumer equal opportunities or any difference in the treatment by reason of age, life expectancy, race, color, national origin, sex, present or predicted disability, degree of medical dependency, quality of life, present or predicted diagnosis, disease or health condition.

(4) "Essential health benefits" means at least the ten categories of health care benefits and the items and services within those categories that must be covered by qualified health plans certified to be offered for sale through the exchange.

(5) "Exchange" means the West Virginia Health Benefit Exchange or an exchange website operated by the federal government.

(6) "Health care provider" means a provider of medical or health services, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

(7) "Health carrier" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

(8) "Network" means a group of health care providers that have contracted with a health plan to provide care at a discounted rate.

(9) "Qualified health plan" means a health plan certified to be offered for sale through the

exchange.

(10) "West Virginia Health Benefit Exchange" means the government-regulated marketplace of qualified health plans with multiple levels of coverage established pursuant to article sixteen-g, chapter thirty-three of this code.

§33-50-2. Information available to the public and disclosures required of health carriers.

The commissioner shall publish, either on his or her website or the website of each health carrier, and if the West Virginia Health Benefit Exchange operates its own website, shall publish on such website, the following information about each qualified health plan offered for sale through the exchange:

(1) The names of all physicians, hospitals and other health care providers that are in network;

(2) A list of all the types of specialists that are in network;

(3) Any exclusion from coverage in each category of benefits;

(4) Any restrictions on use or quantity of covered items and services in each category of benefits;

(5) A description of how medications will specifically be included in or excluded from the deductible, including a description of out-of-pocket costs that may not apply to the deductible for a medication;

(6) The specific dollar amount of any copay or percentage coinsurance for each item or service;

(7) The ability to determine whether a specific drug is available on formulary, the applicable cost-sharing requirement, whether a specific drug is covered when furnished by a physician or clinic,

and any clinical prerequisites or authorization requirements for coverage of a drug;

(8) The process for a patient to appeal a health plan decision where an item or service prescribed or ordered by the treating physician has been denied; and

(9) An explanation of the amount of coverage for out-of-network providers or noncovered services, and any rights of appeal that exist when out-of-network providers or noncovered services are medically necessary.

§33-50-3. Prevention of discriminatory practices annual report.

(a) The commissioner shall submit an annual report by December 31 of each year to the Governor and the Legislative Oversight Commission on Health and Human Resources Accountability detailing and evaluating each qualified health plan for sale to consumers through the exchange.

(b) The annual report shall include:

(1) A description of each qualified health plan's compliance with the required coverage of essential health benefits;

(2) Whether any qualified health plan employed discriminatory practices, any corrective measures taken by the commissioner, and whether the corrective measures rectified the discriminatory practices;

(3) An assessment of qualified health plans to ensure they do not impermissibly impose clinical prerequisites by limiting care available to those who are sicker, or who have a shorter life expectancy, including consideration of benefit design features such as:

(A) The categories of benefits included;

(B) Specific exclusion of named therapies or conditions;

(C) The manner in which coverage decisions are made;

(D) Differential reimbursement rates or cost sharing for covered benefits;

(E) Clinical prerequisites or heightened administrative requirements based on the patient's disease, disability, quality or expected length of life;

(F) Incentive programs; and

(G) The burdensomeness or delay of an applicable exceptions process.

(4) To the extent that discriminatory practices are identified in existing qualified health plans during the course of a plan year, the report shall identify such practices in detail and shall identify the steps taken to prevent such discriminatory practices from being approved as part of future plan offerings.

(c) Each report shall be published on the West Virginia Insurance Commission website upon completion.

§33-50-4. Rule-making authority.

The commissioner shall propose rules for legislative approval, in accordance with the provisions of article three, chapter twenty-nine-a of this code, to implement the provisions of this article, including disciplinary actions and administrative penalties for health carriers utilizing discriminatory practices and for health carriers failing to provide the information requested by the requirements of this article.

NOTE: The purpose of this bill is to enact the Patient Protection and Transparency Act which requires information to be given to, and provides protections for, persons who purchase insurance through the West Virginia Health Benefit Exchange or an exchange website operated by the federal government.

This article is new, therefore, strike-throughs and underscoring have been omitted.