WEST VIRGINIA LEGISLATURE

2019 REGULAR SESSION

Introduced

Senate Bill 591

BY SENATORS MARONEY, PLYMALE, TARR, SYPOLT, AND

BOSO

[Introduced February 13, 2019; Referred

to the Committee on Banking and Insurance]

A BILL to amend and reenact §33-45-1 of the Code of West Virginia, 1931, as amended, relating to defining certain terms used in insurance.

Be it enacted by the Legislature of West Virginia:

ARTICLE 45. ETHICS AND FAIRNESS IN INSURER BUSINESS PRACTICES.

§33-45-1. Definitions.

As used in this article:

(1) “Claim” means each individual request for reimbursement or proof of loss made by or on behalf of an insured or a provider to an insurer, or its intermediary, administrator or representative, with which the provider has a provider contract for payment for health care services under any health plan.

(2) “Clean claim” means a claim: (A) That has no material defect or impropriety, including all reasonably required information and substantiating documentation, to determine eligibility or to adjudicate the claim; or (B) with respect to which an insurer has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with section two of this article.

(3) “Commissioner” means the Insurance Commissioner of West Virginia.

(4) “Health care services” means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical or mental disability.

(5) “Health plan” means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan; medical or hospital services plan as defined in article twenty four of this chapter; accident and sickness insurance policy or certificate; managed care health insurance plan, or health maintenance organization subject to state regulation pursuant to §33-25a-1 *et seq.,* of this code; which is offered, arranged, issued or administered in the state by an insurer authorized under this chapter, a third-party administrator or an intermediary. Health plan does not mean:

(A) Coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §1395

et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. §1397 et seq. (Medicaid), 5 U.S.C. §8901 et seq., or 10 U.S.C. §1071 et seq. (CHAMPUS); or §5-16-1 *et seq.,* of this code (PEIA);

(B) Accident only, credit or disability insurance, long-term care insurance, CHAMPUS supplement, Medicare supplement, workers' compensation coverages or limited benefits policy as defined in article sixteen-e of this chapter; or

(C) Any third-party administrator or an intermediary acting on behalf of providers as denoted in subparagraphs (A) and (B).

(6) “Insured” means a person who is provided health insurance coverage or other health care services coverage from an insurer under a health plan.

(7) “Insurer” means any person required to be licensed under this chapter which offers or administers as a third party administrator health insurance; operates a health plan subject to this chapter; or provides or arranges for the provision of health care services through networks or provider panels which are subject to regulation as the business of insurance under this chapter. “Insurer” also includes intermediaries. “Insurer” does not include:

(A) Credit accident and sickness insurance;

(B) Accident and sickness policies which provide benefits for loss of income due to disability;

(C) Any policy of liability of workers' compensation insurance;

(D) Hospital indemnity or other fixed indemnity insurance;

(E) Life insurance, including endowment or annuity contracts, or contracts supplemental thereto, which contain only provisions relating to accident and sickness insurance that:

(i) Provide additional benefits in cases of death by accidental means; or

(ii) Operate to safeguard the contracts against lapse, in the event that the insured shall become totally and permanently disabled as defined by the contract or supplemental contract; and

(F) Property and casualty insurance.

(8) “Provider contract” means any contract between a provider and

(A) An insurer;

(B) A health plan; or

(C) An intermediary, relating to the provision of health care services.

(9) “Retroactive denial” means the practice of denying previously paid claims by withholding or setting off against payments, or in any other manner reducing or affecting the future claim payments to the provider, or to seek direct cash reimbursement from a provider for a payment previously made to the provider.

(10) “Provider” means a person or other entity which holds a valid license to provide specific health care services in this state.

(11) “Intermediary” means a physician, hospital, physician-hospital organization, independent provider organization or independent provider network which receives compensation for arranging one or more health care services to be rendered by providers to insureds of a health plan or insurer. An intermediary does not include an individual provider or group practice that utilizes only its employees, partners or shareholders and their professional licenses to render services.

(12) “Valid license” includes a license or temporary permit issued pursuant to the provisions of §30-3-1 *et seq.*, and §30-14-1 *et seq.*, of this code.

NOTE: The purpose of this bill is to clarify that valid license includes a temporary permit issued by a Chapter 30 board.

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