

WEST VIRGINIA LEGISLATURE

2019 REGULAR SESSION

Introduced

House Bill 3019

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ATKINSON, ELLINGTON, WORRELL, FAST, BIBBY AND
PORTERFIELD

[Introduced February 12, 2019; Referred
to the Committee on Health and Human Resources
then the Judiciary.]

1 A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article,
2 designated §16-1D-1, §16-1D-2, §16-1D-3, and §16-1D-4; and to amend said code by
3 adding thereto three new sections, designated §33-15-4s, §33-15-4t and §33-15-22, all
4 relating generally to transparency in health care; creating the Health Care Transparency
5 Act; requiring the Bureau for Public Health to produce an estimate for creating and
6 maintaining a health care price transparency tool, with technical support from the Health
7 Care Authority, that is accessible by the public; setting forth transparency tool
8 requirements; establishing new disclosure requirements for health care providers,
9 hospitals, and insurers; requiring insurers to develop an access plan for consumers;
10 establishing how surprise bills are to be handled in certain circumstances; defining the
11 term “surprise bill;” and requiring rule-making.

Be it enacted by the Legislature of West Virginia:

CHAPTER 16. PUBLIC HEALTH.

ARTICLE 1D. HEALTH CARE TRANSPARENCY ACT.

§16-1D-1. Health care price transparency tool.

1 The Bureau for Public Health shall produce an estimate for creating and maintaining a
2 health care price transparency tool, with technical support from the Health Care Authority that is
3 accessible by the public.

§16-1D-2. Comparative analysis.

1 (a) The Bureau for Public Health shall publish compilations or reports that compare and
2 identify health care providers or data suppliers from the data it collects under this article or from
3 any other source.

4 (b)(1) Except as provided in subdivision (3), subsection (h) of this section, the Bureau for
5 Public Health shall publish compilations or reports from the data it collects under this chapter or
6 from any other source which:

7 (A) Contain the information described in subdivision (2) of this subsection; and

8 (B) Compare and identify by name at least a majority of the health care facilities, health
9 care plans, and institutions in the state.

10 (2) Except as provided in subdivision (3), subsection (h) of this section, the report required
11 by this subsection shall:

12 (A) Be published at least annually;

13 (B) List, as determined by the Bureau for Public Health, the median paid amount for the
14 top 50 medical procedures performed in the state by volume;

15 (C) Describe the methodology approved by the Bureau for Public Health to determine the
16 amounts described in paragraph (B) of this subdivision; and

17 (D) Contain comparisons based on at least the following factors:

18 (i) Nationally or other generally recognized quality standards;

19 (ii) Charges; and

20 (iii) Nationally recognized patient safety standards.

21 (c)(1) The Bureau for Public Health may contract with a private, independent analyst to
22 evaluate the standard comparative reports that identify, compare, or rank the performance of data
23 suppliers by name.

24 (2) The evaluation described in this subsection shall include a validation of statistical
25 methodologies, limitations, appropriateness of use, and comparisons using standard health
26 services research practice.

27 (3) The independent analyst described in subdivision (1) of this subsection shall be
28 experienced in analyzing large databases from multiple data suppliers and in evaluating health
29 care issues of cost, quality, and access.

30 (4) The results of the analyst's evaluation shall be released to the public before the
31 standard comparative analysis upon which it is based may be published by the Bureau for Public
32 Health.

33 (d) The Bureau for Public Health may contract with an independent entity to:

34 (1) Publicize the compilations or reports described in this section;

35 (2) Convene a work group to provide recommendations to the Bureau for Public Health on
36 actions that the state could take based on the compilations or reports described in this section;

37 and

38 (3) Identify future applications of the data in a report to the Legislative Oversight
39 Commission on Health and Human Resources Accountability.

40 (e) The Bureau for Public Health shall adopt by rule, a timetable for the collection and
41 analysis of data from multiple types of data suppliers.

42 (f) The comparative analysis required under subsection (b) of this section shall be
43 available free of charge and easily accessible to the public.

44 (g)(1) The Bureau for Public Health shall include in the report required by subdivision (2),
45 subsection (b) of this section or include in a separate report, comparative information on
46 commonly recognized or generally agreed upon measures of cost and quality identified in
47 accordance with subsection (h) of this section for:

48 (A) Routine and preventive care; and

49 (B) The treatment of diabetes, heart disease, and other illnesses or conditions as
50 determined by the Bureau for Public Health.

51 (2) The comparative information required by subdivision (1) of this shall be based on data
52 collected under subsection (b) of this section and clinical data that may be available to the Bureau
53 for Public Health, and shall compare:

54 (A) Results for health care facilities or institutions;

55 (B) Results for health care providers by geographic regions of the state;

56 (C) A clinic's aggregate results for a physician who practices at a clinic with five or more
57 physicians; and

58 (D) A geographic region's aggregate results for a physician who practices at a clinic with

59 less than five physicians, unless the physician requests physician-level data to be published on a
60 clinic level.

61 (3) The Bureau for Public Health:

62 (A) Shall publish information required by this subsection (g) of this section directly or
63 through one or more nonprofit, community-based health data organizations;

64 (B) May use a private, independent analyst under subdivision (1), subsection (c) of this
65 section in preparing the report required by this section; and

66 (C) Shall identify and report to the Legislative Oversight Commission on Health and
67 Human Resources Accountability by July 1, 2020, and every July 1 thereafter until July 1, 2026,
68 at least three new measures of quality to be added to the report each year.

69 (4) A report published by the Bureau for Public Health under this subsection (g) of this
70 section shall, prior to being published, be submitted to a neutral, nonbiased entity with a broad
71 base of support from health care payers and health care providers in accordance with subsection
72 (h) of this section for the purpose of validating the report.

73 (h)(1) The Bureau for Public Health, for purposes of subdivision (1), subsection (g) of this
74 section, shall use the quality measures that are developed and agreed upon by a neutral,
75 nonbiased entity with a broad base of support from health care payers and health care providers.

76 (2) If the entity described in subdivision (1) of this subsection does not submit the quality
77 measures, the Bureau for Public Health may select the appropriate number of quality measures
78 for purposes of the report required by subsection (g) of this section.

79 (3)(A) For purposes of the reports published on or after July 1, 2019, the Bureau for Public
80 Health may not compare individual facilities or clinics as described in paragraphs (A) through (D),
81 subdivision (2), subsection (g) of this section if the Bureau for Public Health determines that the
82 data available to the Bureau for Public Health cannot be appropriately validated, does not
83 represent nationally recognized measures, does not reflect the mix of cases seen at a clinic or
84 facility, or is not sufficient for the purposes of comparing providers.

85 (B) The Bureau for Public Health shall report to the Legislative Oversight Commission on
86 Health and Human Resources Accountability prior to making a determination not to publish a
87 report under paragraph (A) of this subdivision.

§16-1D-3. Health care price transparency tool; project scoping; requirements.

1 (a) On or before October 1, 2019, the Bureau for Public Health shall:

2 (1) With technical support from the Health Care Authority produce an estimate of the cost
3 of creating and maintaining a health care price transparency tool described in this section; and

4 (2) Report to the Legislative Oversight Commission on Health and Human Resources
5 Accountability:

6 (A) The estimate described in subdivision (1) of this subsection;

7 (B) Other policy options for increasing health care price transparency; and

8 (C) If applicable, the Bureau for Public Health's plans for creating a health care price
9 transparency tool in accordance with this section.

10 (b) The Bureau for Public Health may create a health care price transparency tool:

11 (1) Subject to appropriations from the Legislature and any available funding from third-
12 party sources;

13 (2) With technical support from the Health Care Authority; and

14 (3) In accordance with the requirements in subsection (c) of this section.

15 (c) A health care price transparency tool created by the Bureau for Public Health under
16 this section shall:

17 (1) Present health care price information for consumers in a manner that is clear and
18 accurate;

19 (2) Be available to the public through a user-friendly online portal;

20 (3) Incorporate existing collected data;

21 (4) Group billing codes for common health care procedures;

22 (5) Be updated on a regular basis; and

23 (6) Be created and operated in accordance with all applicable state and federal laws.

24 (d) The Bureau for Public Health may make the health care pricing data from the health
25 care price transparency tool available to the public through an application program interface
26 format if the data meets state and federal data privacy requirements.

27 (e) The Bureau for Public Health may contract with one or more state agencies to create
28 a health care price transparency tool described in this section.

29 (f) If the Bureau for Public Health creates a health care price transparency tool, the Bureau
30 for Public Health shall outline steps to minimize the cost of maintaining the health care price
31 transparency tool.

32 (g) Before making a health care price transparency tool available to the public, the Bureau
33 for Public Health shall:

34 (1) Seek input from third-party payers, health care providers, health care facilities, and
35 other stakeholders on the overall accuracy and effectiveness of the reports created by the
36 healthcare price transparency tool;

37 (2) Present a draft of the health care price transparency tool to the Legislative Oversight
38 Commission on Health and Human Resources Accountability;

39 (3) Establish a written procedure to correct any material errors within a reasonable period
40 of time if a data supplier submits any corrections of errors with supporting evidence and
41 comments; and

42 (4) Create a plan to review and report to the Bureau for Public Health on the utilization of
43 the healthcare price transparency tool at least once in each 12 month period.

44 (h) Each year in which a healthcare price transparency tool is operational, the Bureau for
45 Public Health shall report to the Legislative Oversight Commission on Health and Human
46 Resources Accountability before November 1 of that year:

47 (1) The utilization of the health care price transparency tool; and

48 (2) Policy options for improving access to health care price transparency data.

§16-1D-4.Rule-making.

1 The Commissioner of the Bureau for Public Health shall propose rules for legislative
2 approval in accordance with §29A-3-1 et seq. of this code to implement this article.

CHAPTER 33. INSURANCE.**ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.****§33-15-4s. Additional mandatory policy provision.**

1 (a) Except as provided in §33-15-6 of this code, and in addition to all other policy
2 provisions required in this article, each policy delivered or issued for delivery to any person in this
3 state shall contain the provision specified in subsection (b) of this section in the words in which
4 the same appear in this section: *Provided*, That the insurer may, at its option, substitute its own
5 provision of different wording approved by the commissioner that is not less favorable in any
6 respect to the insured or the beneficiary. That provision shall be preceded individually by the
7 caption appearing in this section or, at the option of the insurer, by such appropriate individual or
8 group captions or subcaptions as the commissioner may approve.

9 (b) The provision shall contain an access plan that includes the following components:

10 (1) The insurer's network, including how the use of telemedicine or telehealth or other
11 technology may be used to meet network access standards;

12 (2) The insurer's procedures for making and authorizing referrals within and outside its
13 network, if applicable;

14 (3) The insurer's process for monitoring and assuring on an ongoing basis the sufficiency
15 of the network to meet the health care needs of populations that enroll in network plans;

16 (4) The insurer's process for making available in consumer-friendly language the criteria
17 it has used to build its provider network, including information about the breadth of the network
18 and the criteria used to select or rank providers, which must be made available through the health
19 carrier's on-line and in-print provider directories;

20 (5) The insurer's efforts to address the needs of covered persons who may face barriers
21 to access to care, including, but not limited to, children with serious, chronic or complex medical
22 conditions, individuals with limited English proficiency and illiteracy, individuals with diverse
23 cultural and ethnic backgrounds, and individuals with physical and mental disabilities;

24 (6) The insurer's methods for assessing the health care needs of covered persons and
25 their satisfaction with services;

26 (7) The insurer's method of informing covered persons of the plan's services and features,
27 including, but not limited to, the plan's grievance procedures, its process for choosing and
28 changing providers, its process for updating its provider directories for each of its network plans,
29 a statement of services offered, including those services offered through the preventative care
30 benefit, if applicable, and its procedures for providing and approving emergency and specialty
31 care;

32 (8) The insurer's system for ensuring the coordination and continuity of care for covered
33 persons referred to specialty physicians, for covered persons using ancillary services, including
34 social services and other community resources, and for ensuring appropriate discharge planning;

35 (9) The insurer's process for enabling covered persons to change primary care
36 professionals;

37 (10) The insurer's proposed plan for providing continuity of care in the event of contract
38 termination between the health carrier and any of its participating providers, or in the event of the
39 health carrier's insolvency or other inability to continue operations. The description shall explain
40 how covered persons will be notified of the contract termination, or the health carrier's insolvency
41 or other cessation of operations, and transferred to other providers in a timely manner;

42 (11) The insurer's process for monitoring access to physician specialist services in
43 emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory
44 services at their participating hospitals; and

45 (12) Any other information required by the commissioner to determine compliance with the

46 provisions of this article.

§33-15-4t. Required disclosures.

1 (a) Health care providers shall:

2 (1) Disclose to patients and prospective patients, in writing or through their website, their
3 plan and hospital affiliations prior to the provision of nonemergency services and verbally at the
4 time an appointment is scheduled.

5 (2) An out of network provider shall inform the patient, prior to providing nonemergency
6 services that: (A) The actual or estimated amount for the service is available upon request, and
7 (B) if requested, will be disclosed in writing with a warning that costs could go up if unanticipated
8 complications occur.

9 (b) Physicians, in addition to the foregoing, shall provide a patient and the inpatient or
10 outpatient hospital in which the patient is scheduled for admission with the name, practice name,
11 mailing address and phone number of any other physician scheduled to treat the patient and
12 information as to how to determine the health plan in which the provider participates.

13 (c)(1) Hospitals shall post the following information on their website:

14 (A) Standard charges for services provided by the hospital, including diagnosis-related
15 groups (DRGs);

16 (B) The health plans in which they participate;

17 (C) A warning that: (A) Charges for health care providers who provide services in the
18 hospital are not part of the hospital's charges; and (B) health care providers who provide services
19 in the hospital may not be in the same networks as the hospital; and

20 (D) The name, address and phone number of both contracted specialty practice group
21 providers and employed physicians, together with information regarding how they can be
22 contacted to determine their plan affiliations.

23 (2) In addition, in the registration and admission materials provided in advance of the
24 provision of nonemergency services, hospitals shall: (A) Advise patients to check with the health

25 care provider arranging their services to determine the name, address and phone number of any
26 other health care provider involved in the patient's care, and whether any employed or contracted
27 specialty physicians are expected to participate in the patient's care; and (B) provide patients with
28 information regarding how they can timely determine the health plans in which the health care
29 providers participate.

30 (d) Health plans shall:

31 (1) Provide information in writing and on the Internet that allows consumers to estimate
32 anticipated out-of-pocket costs for out of network services in a particular geographical area based
33 on the difference between what the insurer will reimburse for the out of network services and the
34 usual and customary costs for the out of network services.

35 (2) Upon request from an enrollee or prospective enrollee, disclose the approximate dollar
36 amount that the insurer will pay for a particular out of network service but that the approximation
37 is not binding on the insurer and may change.

§33-15-22. Coverage of surprise bills.

1 (a) In order to be protected from surprise bills, the consumer must sign an assignment of
2 benefits form which will enable the provider to seek payment directly from the consumer's insurer
3 by submitting the assignment of benefit form along with a copy of the bill believed to be a surprise
4 bill. Upon payment of a reasonable payment of a surprise bill, the provider can dispute the amount
5 through an independent dispute resolution process established by the commissioner.

6 (b) The independent dispute process shall consider, among other things, whether there is
7 a significant disparity between the fee charged by the health care provider as compared to other
8 fees paid to similarly qualified out-of-network providers in the same region, the level of training
9 and education of the health care provider, and the complexity and circumstances of the case.

10 (c) For the purposes of this section "surprise bill" means an invoice for health care
11 services, other than emergency services, received by a patient in one of three circumstances:

12 (1) An insured receives services from an out-of-network health care provider at an in-

13 network hospital or ambulatory surgery center, where a participating health care provider is
14 unavailable or an out-of-network health care provider renders services without the patient's
15 knowledge.

16 (2) An insured receives services from an out-of-network health care provider, where the
17 services were referred by an in-network provider without the patient's express written
18 acknowledgment that the referral is to an out-of-network provider, and that the referral may result
19 in costs not covered in the health plan.

20 (3) An uninsured patient receives services at a hospital or ambulatory surgery center and
21 does not receive the disclosures required in §33-15-4(b)(1) of this code.

NOTE: The purpose of this bill is to address general concerns about transparency in health care. The bill creates the Health Care Transparency Act. The bill requires the Bureau for Public Health to produce an estimate for creating and maintaining a health care price transparency tool, with technical support from the Health Care Authority, that is accessible by the public. The bill sets forth transparency tool requirements. The bill requires rule-making. The bill establishes new disclosure requirements for health care providers, hospitals, and insurers. The bill requires insurers develop an access plan for consumers. The bill establishes how surprise bills are to be handled in certain circumstances, and defines the term "surprise bill."

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