Senate Bill No. 296

(By Senator Cann)

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[Introduced January 8, 2014; referred to the Committee on Banking and Insurance; and then to the Committee on the Judiciary.]

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A BILL to repeal §33-4-7 of the Code of West Virginia, 1931, as amended; to amend said code by adding thereto a new section, designated §33-1-22; to amend and reenact §33-4-8 of said code; to amend and reenact §33-15-4d and §33-15-14 of said code; to amend said code by adding thereto a new section, designated §33-15-22; to amend and reenact §33-16-3h and §33-16-10 of said code; to amend said code by adding thereto a new section, designated §33-16-18; to amend said code by adding thereto three new sections, designated §33-16D-17, §33-16D-18 and §33-16D-19; to amend and reenact §33-24-7c and §33-24-43 of said code; to amend said code by adding thereto a new section, designated §33-24-7m; to amend and reenact §33-25-8b of said code; to amend said code by adding thereto a new section, designated §33-25-8j; to amend and reenact

§33-25-20 of said code; to amend and reenact §33-25A-8b of said code; to amend said code by adding thereto a new section, designated §33-25A-8l; to amend and reenact §33-25A-3l of said code; and to amend said code by adding thereto two new sections, designated §33-28-8 and §33-28-9, all relating to creating the West Virginia Fair Health Insurance Act of 2014; defining "illusionary benefit" to require benefits to cover at least seventy-five percent of health care service; establishing reasonable copays among common insurance needs; preventing insurance companies from discriminating against licensed health care practitioners to whom they will pay for a covered service; preventing insurance companies from arbitrarily defining medically necessary rehabilitation services to avoid making payment for a covered service or for a service that should be covered; making physical therapy and rehabilitation services a mandated covered service for any health insurance plan; and increasing the monetary criminal penalty for insurance companies that violate any provisions of the chapter.

Be it enacted by the Legislature of West Virginia:

That §33-4-7 of the Code of West Virginia, 1931, as amended, be repealed; that said code be amended by adding thereto a new section, designated §33-1-22; that §33-4-8 of said code be amended

and reenacted; that §33-15-4d and §33-15-14 of said code be amended and reenacted; that said code be amended by adding thereto a new section, designated §33-15-22; that §33-16-3h and §33-16-10 of said code be amended and reenacted; that said code be amended by adding thereto a new section, designated §33-16-18; that said code be amended by adding thereto three new sections, designated §33-16D-17, §33-16D-18 and §33-16D-19; that §33-24-7c of said code be amended and reenacted; that §33-24-43 of said code be amended and reenacted; that said code be amended by adding thereto a new section, designated §33-24-7m; that §33-25-8b of said code be amended and reenacted; that said code be amended by adding thereto a new section, designated §33-25-8j; that §33-25-20 of said code be amended and reenacted; that §33-25A-8b of said code be amended and reenacted; that said code be amended by adding thereto a new section, designated §33-25A-81; that §33-25A-31 of said code be amended and reenacted; and that said code be amended by adding thereto two new sections, designated §33-28-8 and §33-28-9, all to read as follows:

ARTICLE 1. DEFINITIONS.

§33-1-22. Illusory benefit and policy.

"Illusory benefit" means a copayment, or coinsurance, or codeductible, or combination thereof, outside of the annual contract deductible, which exceeds twenty-five percent of the

contractual fee paid by an accident and sickness insurance company, fraternal benefit society, nonprofit health service corporation, nonprofit hospital service corporation, nonprofit medical service corporation, prepaid health plan, dental care plan, vision care plan, pharmaceutical plan, health maintenance organization, and all similar type organizations to the network provider for covered services under the beneficiary's health insurance policy.

"Policy" means any policy, contract, plan or agreement of accident and sickness insurance, and credit accident and sickness insurance, delivered or issued for delivery in this state by any company subject to this article; any certificate, contract or policy issued by a fraternal benefit society; and any certificate issued pursuant to a group insurance policy delivered or issued for delivery in this state.

An insurer is prohibited from issuing policy that imposes an illusory benefit on beneficiaries for services provided by any of its network providers.

ARTICLE 4. GENERAL PROVISIONS.

§33-4-8. General penalty.

In addition to the refusal to renew, suspension or revocation of a license, or penalty in lieu of the foregoing, because of violation of any provision of this chapter, it is a misdemeanor for any person to violate any provision of this chapter unless the

violation is declared to be a felony by this chapter or other law of this state. Unless another penalty is provided in this chapter or by the laws of this state, every person convicted of a misdemeanor for the violation of any provision of this chapter shall be fined not ~~more~~ less than $1,000 per occurrence nor more than §10,000 per occurrence or confined in jail not more than six months, or both fined and confined.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4d. Third party reimbursement for rehabilitation services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, ~~1991~~ 2014, provide as benefits to all subscribers and members coverage for rehabilitation services as hereinafter set forth, unless rejected by the insured.

(b) *Medically necessary rehabilitation services.* -- Rehabilitation, as part of an individual's health care, is considered medically necessary as determined by the qualified health care provider based on the results of an evaluation and when provided for the purpose of preventing, minimizing or eliminating impairments, activity limitations or participation restrictions. Rehabilitation services are delivered throughout the episode of care by the qualified health care provider or under his or her

direction and supervision; requires the knowledge, clinical judgment, and abilities of the qualified health care provider; takes into consideration the potential benefits and harms to the patient/client; and is not provided exclusively for the convenience of the patient/client. Rehabilitation services are provided using evidence of effectiveness and applicable standards of practice and is considered medically necessary if the type, amount and duration of services outlined in the plan of care increase the likelihood of meeting one or more of these stated goals: to improve function, minimize loss of function, or decrease risk of injury and disease.

~~(b)~~ (c) For purposes of this article and section, "rehabilitation services" includes those services which are designed to remediate patient's condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status. Rehabilitative services include by illustration and not limitation diagnostic testing, assessment, monitoring or treatment of the following conditions individually or in a combination:

(1) Stroke;

(2) Spinal cord injury;

(3) Congenital deformity;

(4) Amputation;

(5) Major multiple trauma;

(6) Fracture of femur;

(7) Brain injury;

(8) Polyarthritis, including rheumatoid arthritis;

(9) Neurological disorders, including, but not limited to, multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy and Parkinson's disease;

(10) Cardiac disorders, including, but not limited to, acute myocardial infarction, angina pectoris, coronary arterial insufficiency, angioplasty, heart transplantation, chronic arrhythmias, congestive heart failure, valvular heart disease;

(11) Burns;

(12) Orthopedic Disorders;

(13) Chronic Diseases including, but not limited to, diabetes, hypertension and obesity;

(14) Fall prevention and treatment;

~~(c)~~ (d) Rehabilitative services includes care rendered by any of the following:

(1) A hospital duly licensed by the State of West Virginia that meets the requirements for rehabilitation hospitals as described in Section 2803.2 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(2) A distinct part rehabilitation unit in a hospital duly

licensed by the State of West Virginia. The distinct part unit must meet the requirements of Section 2803.61 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(3) A hospital duly licensed by the State of West Virginia which meets the requirements for cardiac rehabilitation as described in Section 35-25, Transmittal 41, dated August, 1989, as promulgated by the U.S. Health Care Financing Administration.

(4) Physical Therapists, Occupational Therapists and Speech Language Pathologists; (qualified health care professionals currently authorized under federal law (*42 C.F.R. § 484.4*)

~~(d)~~ (e) Rehabilitation services do not include services for mental health, chemical dependency, vocational rehabilitation, long-term maintenance or custodial services.

~~(e)~~ (f) A policy, provision, contract, plan or agreement may apply to rehabilitation services the same deductibles, coinsurance and other limitations as apply to other covered services.

§33-15-14. Policies discriminating among health care providers.

Notwithstanding any other provisions of law, when any health insurance policy, health care services plan or other contract provides for the payment of medical expenses, benefits or procedures, ~~such~~ the policy, plan or contract shall be construed to include payment to all health care providers including, but not

limited to, medical physicians, osteopathic physicians, podiatric physicians, chiropractic physicians, physical therapists, occupational therapists, midwives, ~~and~~ nurse practitioners and their licensed assistants, who provide medical services, benefits or procedures which are within the scope of each respective provider's license. Any limitation or condition placed upon services, diagnoses or treatment by, or payment to any particular type of licensed provider shall apply equally to all types of licensed providers without unfair discrimination as to the usual and customary treatment procedures of any of the aforesaid providers.

§33-15-22. Copayments and coinsurance.

"Copayment" means a specific dollar amount or percentage not to exceed twenty-five percent of covered charges, except as otherwise provided by statute, that the subscriber must pay upon receipt of covered health care services and which is set at an amount or percentage consistent with allowing subscriber access to health care services.

(a) Copayments in health benefit plans may not exceed the following amounts:

(1) Preventive services, $30;

(2) Primary care provider office visit, including physical, occupational and speech therapists, $30;

(3) Specialist physician office visit, $75;

(4) Emergency room visit, $100;

(5) Outpatient surgery, $500;

(6) Inpatient admission, $500 per day up to a maximum of $2,500 per admission;

(7) Magnetic resonance imaging, computerized axial tomography and positron emission tomography, $100;

(8) For any other services and supplies, the copayment is to be determined so that the carrier insures seventy-five percent or more of the aggregate risk for the service or supply to which the copayment is applied.

(b) Network copayment may not be applied to any service or supply to which network coinsurance is applied.

(c)"Family out-of-pocket limit" means the maximum dollar amount that a family shall pay in combination as copayment, deductible and coinsurance for network covered services and supplies in a calendar, contract or policy year.

(d)"Individual out-of-pocket limit" means the maximum dollar amount that a covered person shall pay as copayment, deductible and coinsurance for services and supplies provided by network providers in a calendar, contract or policy year.

(e)"Network coinsurance" means the percentage of the contractual fee of the network provider for covered services and

supplies specified in the contract between the provider and the carrier that must be paid by the covered person, under the health benefit plan, subject to network deductible and network out-of-pocket limit.

(f) All amounts paid as copayment, coinsurance and deductible count toward the out-of-pocket limit, and may not be excluded because of the nature of the service rendered, the illness or condition being treated, or for any other reason, except carriers may, provided the terms of the health benefit plan so state, elect to exclude from the out-of-pocket limit the cost sharing associated with prescription drug coverage, whether provided as part of the health benefit plan or as a rider.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3h. Third party reimbursement for rehabilitation services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, ~~1991~~ 2014, provide as benefits to all subscribers and members coverage for rehabilitation services as hereinafter set forth, unless rejected by the insured.

(b) *Medically necessary rehabilitation services.* -- Rehabilitation, as part of an individual's health care, is considered medically necessary as determined by the qualified

health care provider based on the results of an evaluation and when provided for the purpose of preventing, minimizing or eliminating impairments, activity limitations or participation restrictions. Rehabilitation services are delivered throughout the episode of care by the qualified health care provider or under his or her direction and supervision; requires the knowledge, clinical judgment, and abilities of the qualified health care provider; takes into consideration the potential benefits and harms to the patient/client; and is not provided exclusively for the convenience of the patient/client. Rehabilitation services are provided using evidence of effectiveness and applicable standards of practice and is considered medically necessary if the type, amount and duration of services outlined in the plan of care increase the likelihood of meeting one or more of these stated goals: to improve function, minimize loss of function, or decrease risk of injury and disease.

~~(b)~~ (c) For purposes of this article and section, "rehabilitation services" includes those services which are designed to remediate patient's condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status. Rehabilitative services include by illustration and not limitation diagnostic testing, assessment, monitoring or treatment of the following conditions individually or in a combination:

(1) Stroke;

(2) Spinal cord injury;

(3) Congenital deformity;

(4) Amputation;

(5) Major multiple trauma;

(6) Fracture of femur;

(7) Brain injury;

(8) Polyarthritis, including rheumatoid arthritis;

(9) Neurological disorders, including, but not limited to, multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy and Parkinson's disease;

(10) Cardiac disorders, including, but not limited to, acute myocardial infarction, angina pectoris, coronary arterial insufficiency, angioplasty, heart transplantation, chronic arrhythmias, congestive heart failure, valvular heart disease;

(11) Burns;

(12) Orthopedic Disorders;

(13) Chronic Diseases including, but not limited to, diabetes, hypertension and obesity;

(14) Fall prevention and treatment;

~~(c)~~ (d) Rehabilitative services includes care rendered by any of the following:

(1) A hospital duly licensed by the State of West Virginia

that meets the requirements for rehabilitation hospitals as described in Section 2803.2 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(2) A distinct part rehabilitation unit in a hospital duly licensed by the State of West Virginia. The distinct part unit must meet the requirements of Section 2803.61 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(3) A hospital duly licensed by the State of West Virginia which meets the requirements for cardiac rehabilitation as described in Section 35-25, Transmittal 41, dated August, 1989, as promulgated by the U.S. Health Care Financing Administration.

(4) Physical Therapists, Occupational Therapists and Speech Language Pathologists; (qualified health care professionals currently authorized under federal law (*42 C.F.R. § 484.4*)

~~(d)~~ (e) Rehabilitation services do not include services for mental health, chemical dependency, vocational rehabilitation, long-term maintenance or custodial services.

~~(e)~~ (f) A policy, provision, contract, plan or agreement may apply to rehabilitation services the same deductibles, coinsurance and other limitations as apply to other covered services.

§33-16-10. Policies discriminating among health care providers.

Notwithstanding any other provisions of law, when any health insurance policy, health care services plan or other contract provides for the payment of medical expenses, benefits or procedures, ~~such~~ the policy, plan or contract shall be construed to include payment to all health care providers including , but not limited to, medical physicians, osteopathic physicians, podiatric physicians, chiropractic physicians, physical therapists, occupational therapists, midwives, ~~and~~ nurse practitioners and their licensed assistants, who provide medical services, benefits or procedures which are within the scope of each respective provider's license. Any limitation or condition placed upon services, diagnoses or treatment by, or payment to any particular type of licensed provider shall apply equally to all types of licensed providers without unfair discrimination as to the usual and customary treatment procedures of any of the aforesaid providers.

§33-16-18. Copayments and coinsurance.

"Copayment" means a specific dollar amount or percentage not to exceed twenty-five percent of covered charges, except as otherwise provided by statute, that the subscriber must pay upon receipt of covered health care services and which is set at an amount or percentage consistent with allowing subscriber access to health care services.

(a) Copayments in health benefit plans may not exceed the following amounts:

(1) Preventive services, $30;

(2) Primary care provider office visit, including physical, occupational and speech therapists, $30;

(3) Specialist physician office visit, $75;

(4) Emergency room visit, $100;

(5) Outpatient surgery, $500;

(6) Inpatient admission, $500 per day up to a maximum of $2,500 per admission;

(7) Magnetic resonance imaging, computerized axial tomography and positron emission tomography, $100;

(8) For any other services and supplies, the copayment is to be determined so that the carrier insures seventy-five percent or more of the aggregate risk for the service or supply to which the copayment is applied.

(b) Network copayment may not be applied to any service or supply to which network coinsurance is applied.

(c)"Family out-of-pocket limit" means the maximum dollar amount that a family shall pay in combination as copayment, deductible and coinsurance for network covered services and supplies in a calendar, contract or policy year.

(d)"Individual out-of-pocket limit" means the maximum dollar

amount that a covered person shall pay as copayment, deductible and coinsurance for services and supplies provided by network providers in a calendar, contract or policy year.

(e)"Network coinsurance" means the percentage of the contractual fee of the network provider for covered services and supplies specified in the contract between the provider and the carrier that must be paid by the covered person, under the health benefit plan, subject to network deductible and network out-of-pocket limit.

(f) All amounts paid as copayment, coinsurance and deductible count toward the out-of-pocket limit, and may not be excluded because of the nature of the service rendered, the illness or condition being treated, or for any other reason, except carriers may, provided the terms of the health benefit plan so state, elect to exclude from the out-of-pocket limit the cost sharing associated with prescription drug coverage, whether provided as part of the health benefit plan or as a rider.

ARTICLE 16D. MARKETING AND RATE PRACTICES FOR SMALL EMPLOYER ACCIDENT AND SICKNESS INSURANCE POLICIES.

§33-16D-17. Copayments and coinsurance.

"Copayment" means a specific dollar amount or percentage not to exceed twenty-five percent of covered charges, except as otherwise provided by statute, that the subscriber must pay upon

receipt of covered health care services and which is set at an amount or percentage consistent with allowing subscriber access to health care services.

(a) Copayments in health benefit plans may not exceed the following amounts:

(1) Preventive services, $30;

(2) Primary care provider office visit, including physical, occupational and speech therapists, $30;

(3) Specialist physician office visit, $75;

(4) Emergency room visit, $100;

(5) Outpatient surgery, $500;

(6) Inpatient admission, $500 per day up to a maximum of §2,500 per admission;

(7) Magnetic resonance imaging, computerized axial tomography and positron emission tomography, $100;

(8) For any other services and supplies, the copayment is to be determined so that the carrier insures seventy-five percent or more of the aggregate risk for the service or supply to which the copayment is applied.

(b) Network copayment may not be applied to any service or supply to which network coinsurance is applied.

(c)"Family out-of-pocket limit" means the maximum dollar amount that a family shall pay in combination as copayment,

deductible and coinsurance for network covered services and supplies in a calendar, contract or policy year.

(d)"Individual out-of-pocket limit" means the maximum dollar amount that a covered person shall pay as copayment, deductible and coinsurance for services and supplies provided by network providers in a calendar, contract or policy year.

(e)"Network coinsurance" means the percentage of the contractual fee of the network provider for covered services and supplies specified in the contract between the provider and the carrier that must be paid by the covered person, under the health benefit plan, subject to network deductible and network out-of-pocket limit.

(f) All amounts paid as copayment, coinsurance and deductible count toward the out-of-pocket limit, and may not be excluded because of the nature of the service rendered, the illness or condition being treated, or for any other reason, except carriers may, provided the terms of the health benefit plan so state, elect to exclude from the out-of-pocket limit the cost sharing associated with prescription drug coverage, whether provided as part of the health benefit plan or as a rider.

§33-16D-18. Policies discriminating among health care providers.

Notwithstanding any other provisions of law, when any health insurance policy, health care services plan or other contract

provides for the payment of medical expenses, benefits or procedures, the policy, plan or contract shall be construed to include payment to all health care providers including, but not limited to, medical physicians, osteopathic physicians, podiatric physicians, chiropractic physicians, physical therapists, occupational therapists, midwives, nurse practitioners and their licensed assistants, who provide medical services, benefits or procedures which are within the scope of each respective provider's license. Any limitation or condition placed on services, diagnoses or treatment by, or payment to any particular type of licensed provider shall apply equally to all types of licensed providers without unfair discrimination as to the usual and customary treatment procedures of any of the aforesaid providers.

§33-16D-19. Third party reimbursement for rehabilitation services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, 2014, provide as benefits to all subscribers and members coverage for rehabilitation services as hereinafter set forth, unless rejected by the insured.

(b) *Medically necessary rehabilitation services.* -- Rehabilitation, as part of an individual’s health care, is considered medically necessary as determined by the qualified

health care provider based on the results of an evaluation and when provided for the purpose of preventing, minimizing or eliminating impairments, activity limitations or participation restrictions. Rehabilitation services are delivered throughout the episode of care by the qualified health care provider or under his or her direction and supervision; requires the knowledge, clinical judgment, and abilities of the qualified health care provider; takes into consideration the potential benefits and harms to the patient/client; and is not provided exclusively for the convenience of the patient/client. Rehabilitation services are provided using evidence of effectiveness and applicable standards of practice and is considered medically necessary if the type, amount and duration of services outlined in the plan of care increase the likelihood of meeting one or more of these stated goals: to improve function, minimize loss of function, or decrease risk of injury and disease.

(c) For purposes of this article and section, "rehabilitation services" includes those services which are designed to remediate patient's condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status. Rehabilitative services include by illustration and not limitation diagnostic testing, assessment, monitoring or treatment of the following conditions individually or in a combination:

(1) Stroke;

(2) Spinal cord injury;

(3) Congenital deformity;

(4) Amputation;

(5) Major multiple trauma;

(6) Fracture of femur;

(7) Brain injury;

(8) Polyarthritis, including rheumatoid arthritis;

(9) Neurological disorders, including, but not limited to, multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy and Parkinson's disease;

(10) Cardiac disorders, including, but not limited to, acute myocardial infarction, angina pectoris, coronary arterial insufficiency, angioplasty, heart transplantation, chronic arrhythmias, congestive heart failure and valvular heart disease;

(11) Burns;

(12) Orthopedic Disorders;

(13) Chronic Diseases including, but not limited to, diabetes, hypertension and obesity;

(14) Fall prevention and treatment;

(d) Rehabilitative services includes care rendered by any of the following:

(1) A hospital duly licensed by the State of West Virginia that meets the requirements for rehabilitation hospitals as

described in Section 2803.2 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(2) A distinct part rehabilitation unit in a hospital duly licensed by the State of West Virginia. The distinct part unit must meet the requirements of Section 2803.61 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(3) A hospital duly licensed by the State of West Virginia which meets the requirements for cardiac rehabilitation as described in Section 35-25, Transmittal 41, dated August, 1989, as promulgated by the U.S. Health Care Financing Administration.

(4) Physical Therapists, Occupational Therapists and Speech Language Pathologists; (qualified health care professionals currently authorized under federal law (*42 C.F.R. § 484.4*)

(e) Rehabilitation services do not include services for mental health, chemical dependency, vocational rehabilitation, long-term maintenance or custodial services.

(f) A policy, provision, contract, plan or agreement shall apply to rehabilitation services the same deductibles, coinsurance and other limitations as apply to other covered services.

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS AND

HEALTH SERVICE CORPORATIONS.

§33-24-7c. Third party reimbursement for rehabilitation services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, ~~1991~~ 2014, provide as benefits to all subscribers and members coverage for rehabilitation services as hereinafter set forth, unless rejected by the insured.

(b) *Medically necessary rehabilitation services.* -- Rehabilitation, as part of an individual's health care, is considered medically necessary as determined by the qualified health care provider based on the results of an evaluation and when provided for the purpose of preventing, minimizing or eliminating impairments, activity limitations or participation restrictions. Rehabilitation services are delivered throughout the episode of care by the qualified health care provider or under his or her direction and supervision; requires the knowledge, clinical judgment, and abilities of the qualified health care provider; takes into consideration the potential benefits and harms to the patient/client; and is not provided exclusively for the convenience of the patient/client. Rehabilitation services are provided using evidence of effectiveness and applicable standards of practice and is considered medically necessary if the type, amount and duration

of services outlined in the plan of care increase the likelihood of meeting one or more of these stated goals: to improve function, minimize loss of function, or decrease risk of injury and disease.

~~(b)~~ (c) For purposes of this article and section, "rehabilitation services" includes those services which are designed to remediate patient's condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status. Rehabilitative services include by illustration and not limitation diagnostic testing, assessment, monitoring or treatment of the following conditions individually or in a combination:

(1) Stroke;

(2) Spinal cord injury;

(3) Congenital deformity;

(4) Amputation;

(5) Major multiple trauma;

(6) Fracture of femur;

(7) Brain injury;

(8) Polyarthritis, including rheumatoid arthritis;

(9) Neurological disorders, including, but not limited to, multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy and Parkinson's disease;

(10) Cardiac disorders, including, but not limited to, acute

myocardial infarction, angina pectoris, coronary arterial insufficiency, angioplasty, heart transplantation, chronic arrhythmias, congestive heart failure, valvular heart disease;

(11) Burns;

(12) Orthopedic Disorders;

(13) Chronic Diseases including, but not limited to, diabetes, hypertension and obesity;

(14) Fall prevention and treatment.

~~(c)~~ (d) Rehabilitative services includes care rendered by any of the following:

(1) A hospital duly licensed by the State of West Virginia that meets the requirements for rehabilitation hospitals as described in Section 2803.2 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(2) A distinct part rehabilitation unit in a hospital duly licensed by the State of West Virginia. The distinct part unit must meet the requirements of Section 2803.61 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(3) A hospital duly licensed by the State of West Virginia which meets the requirements for cardiac rehabilitation as described in Section 35-25, Transmittal 41, dated August, 1989, as

promulgated by the U.S. Health Care Financing Administration.

(4) Physical Therapists, Occupational Therapists and Speech Language Pathologists; (qualified health care professionals currently authorized under federal law (*42 C.F.R. § 484.4*)

~~(d)~~ (e) Rehabilitation services do not include services for mental health, chemical dependency, vocational rehabilitation, long-term maintenance or custodial services.

~~(e)~~ (f) A policy, provision, contract, plan or agreement may apply to rehabilitation services the same deductibles, coinsurance and other limitations as apply to other covered services.

§33-24-7m. Copayments and coinsurance.

"Copayment" means a specific dollar amount or percentage not to exceed twenty-five percent of covered charges, except as otherwise provided by statute, that the subscriber must pay upon receipt of covered health care services and which is set at an amount or percentage consistent with allowing subscriber access to health care services.

(a) Copayments in health benefit plans may not exceed the following amounts:

(1) Preventive services, $30;

(2) Primary care provider office visit, including physical, occupational and speech therapists, $30;

(3) Specialist physician office visit, $75;

(4) Emergency room visit, $100;

(5) Outpatient surgery, $500;

(6) Inpatient admission, $500 per day up to a maximum of §2,500 per admission;

(7) Magnetic resonance imaging, computerized axial tomography and positron emission tomography, $100;

(8) For any other services and supplies, the copayment is to be determined so that the carrier insures seventy-five percent or more of the aggregate risk for the service or supply to which the copayment is applied.

(b) Network copayment may not be applied to any service or supply to which network coinsurance is applied.

(c)"Family out-of-pocket limit" means the maximum dollar amount that a family shall pay in combination as copayment, deductible and coinsurance for network covered services and supplies in a calendar, contract or policy year.

(d)"Individual out-of-pocket limit" means the maximum dollar amount that a covered person shall pay as copayment, deductible and coinsurance for services and supplies provided by network providers in a calendar, contract or policy year.

(e)"Network coinsurance" means the percentage of the contractual fee of the network provider for covered services and supplies specified in the contract between the provider and the

carrier that must be paid by the covered person, under the health benefit plan, subject to network deductible and network out-of-pocket limit.

(f) All amounts paid as copayment, coinsurance and deductible count toward the out-of-pocket limit, and may not be excluded because of the nature of the service rendered, the illness or condition being treated, or for any other reason, except carriers may, provided the terms of the health benefit plan so state, elect to exclude from the out-of-pocket limit the cost sharing associated with prescription drug coverage, whether provided as part of the health benefit plan or as a rider.

§33-24-43. Policies discriminating among health care providers.

Notwithstanding any other provisions of law, when any health insurance policy, health care services plan or other contract provides for the payment of medical expenses, benefits or procedures, ~~such~~ the policy, plan or contract shall be construed to include payment to all health care providers including, but not limited to, medical physicians, osteopathic physicians, podiatric physicians, chiropractic physicians, physical therapists, occupational therapists, midwives, ~~and~~ nurse practitioners and their licensed assistants, who provide medical services, benefits or procedures which are within the scope of each respective provider's license. Any limitation or condition placed upon

services, diagnoses or treatment by, or payment to any particular type of licensed provider shall apply equally to all types of licensed providers without unfair discrimination as to the usual and customary treatment procedures of any of the aforesaid providers.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8b. Third party reimbursement for rehabilitation services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, ~~1991~~ 2014, provide as benefits to all subscribers and members coverage for rehabilitation services as hereinafter set forth, unless rejected by the insured.

(b) *Medically necessary rehabilitation services.* -- Rehabilitation, as part of an individual's health care, is considered medically necessary as determined by the qualified health care provider based on the results of an evaluation and when provided for the purpose of preventing, minimizing or eliminating impairments, activity limitations or participation restrictions. Rehabilitation services are delivered throughout the episode of care by the qualified health care provider or under his or her direction and supervision; requires the knowledge, clinical judgment and abilities of the qualified health care provider; takes

into consideration the potential benefits and harms to the patient/client; and is not provided exclusively for the convenience of the patient/client. Rehabilitation services are provided using evidence of effectiveness and applicable standards of practice and is considered medically necessary if the type, amount and duration of services outlined in the plan of care increase the likelihood of meeting one or more of these stated goals: to improve function, minimize loss of function, or decrease risk of injury and disease.

~~(b)~~ (c) For purposes of this article and section, "rehabilitation services" includes those services which are designed to remediate patient's condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status. Rehabilitative services include by illustration and not limitation diagnostic testing, assessment, monitoring or treatment of the following conditions individually or in a combination:

(1) Stroke;

(2) Spinal cord injury;

(3) Congenital deformity;

(4) Amputation;

(5) Major multiple trauma;

(6) Fracture of femur;

(7) Brain injury;

(8) Polyarthritis, including rheumatoid arthritis;

(9) Neurological disorders, including, but not limited to, multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy and Parkinson's disease;

(10) Cardiac disorders, including, but not limited to, acute myocardial infarction, angina pectoris, coronary arterial insufficiency, angioplasty, heart transplantation, chronic arrhythmias, congestive heart failure, valvular heart disease;

(11) Burns;

(12) Orthopedic Disorders;

(13) Chronic Diseases including, but not limited to, diabetes, hypertension and obesity;

(14) Fall prevention and treatment;

~~(c)~~ (d) Rehabilitative services includes care rendered by any of the following:

(1) A hospital duly licensed by the State of West Virginia that meets the requirements for rehabilitation hospitals as described in Section 2803.2 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(2) A distinct part rehabilitation unit in a hospital duly licensed by the State of West Virginia. The distinct part unit must meet the requirements of Section 2803.61 of the Medicare

Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(3) A hospital duly licensed by the State of West Virginia which meets the requirements for cardiac rehabilitation as described in Section 35-25, Transmittal 41, dated August, 1989, as promulgated by the U.S. Health Care Financing Administration.

(4) Physical Therapists, Occupational Therapists and Speech Language Pathologists; (qualified health care professionals currently authorized under federal law (*42 C.F.R. § 484.4*)

~~(d)~~ (e) Rehabilitation services do not include services for mental health, chemical dependency, vocational rehabilitation, long-term maintenance or custodial services.

~~(e)~~ (f) A policy, provision, contract, plan or agreement may apply to rehabilitation services the same deductibles, coinsurance and other limitations as apply to other covered services.

§33-25-8j. Copayments and coinsurance.

"Copayment" means a specific dollar amount or percentage not to exceed twenty-five percent of covered charges, except as otherwise provided by statute, that the subscriber must pay upon receipt of covered health care services and which is set at an amount or percentage consistent with allowing subscriber access to health care services.

(a) Copayments in health benefit plans may not exceed the

following amounts:

(1) Preventive services, $30;

(2) Primary care provider office visit, including physical, occupational and speech therapists, $30;

(3) Specialist physician office visit, $75;

(4) Emergency room visit, $100;

(5) Outpatient surgery, $500;

(6) Inpatient admission, $500 per day up to a maximum of $2,500 per admission;

(7) Magnetic resonance imaging, computerized axial tomography and positron emission tomography, $100;

(8) For any other services and supplies, the copayment is to be determined so that the carrier insures seventy-five percent or more of the aggregate risk for the service or supply to which the copayment is applied.

(b) Network copayment may not be applied to any service or supply to which network coinsurance is applied.

(c)"Family out-of-pocket limit" means the maximum dollar amount that a family shall pay in combination as copayment, deductible and coinsurance for network covered services and supplies in a calendar, contract or policy year.

(d)"Individual out-of-pocket limit" means the maximum dollar amount that a covered person shall pay as copayment, deductible and

coinsurance for services and supplies provided by network providers in a calendar, contract or policy year.

(e)"Network coinsurance" means the percentage of the contractual fee of the network provider for covered services and supplies specified in the contract between the provider and the carrier that must be paid by the covered person, under the health benefit plan, subject to network deductible and network out-of-pocket limit.

(f) All amounts paid as copayment, coinsurance and deductible count toward the out-of-pocket limit, and may not be excluded because of the nature of the service rendered, the illness or condition being treated, or for any other reason, except carriers may, provided the terms of the health benefit plan so state, elect to exclude from the out-of-pocket limit the cost sharing associated with prescription drug coverage, whether provided as part of the health benefit plan or as a rider.

§33-25-20. Policies discriminating among health care providers.

Notwithstanding any other provisions of law, when any health insurance policy, health care services plan or other contract provides for the payment of medical expenses, benefits or procedures, ~~such~~ the policy, plan or contract shall be construed to include payment to all health care providers including, but not limited to, medical physicians, osteopathic physicians, podiatric

physicians, chiropractic physicians, physical therapists, occupational therapists, midwives, ~~and~~ nurse practitioners and their licensed assistants, who provide medical services, benefits or procedures which are within the scope of each respective provider's license. Any limitation or condition placed upon services, diagnoses or treatment by, or payment to any particular type of licensed provider shall apply equally to all types of licensed providers without unfair discrimination as to the usual and customary treatment procedures of any of the aforesaid providers.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8b. Third party reimbursement for rehabilitation services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, ~~1991~~ 2014, provide as benefits to all subscribers and members coverage for rehabilitation services as hereinafter set forth, unless rejected by the insured.

(b) *Medically necessary rehabilitation services.* -- Rehabilitation, as part of an individual's health care, is considered medically necessary as determined by the qualified health care provider based on the results of an evaluation and when

provided for the purpose of preventing, minimizing or eliminating impairments, activity limitations or participation restrictions. Rehabilitation services are delivered throughout the episode of care by the qualified health care provider or under his or her direction and supervision; requires the knowledge, clinical judgment, and abilities of the qualified health care provider; takes into consideration the potential benefits and harms to the patient/client; and is not provided exclusively for the convenience of the patient/client. Rehabilitation services are provided using evidence of effectiveness and applicable standards of practice and is considered medically necessary if the type, amount and duration of services outlined in the plan of care increase the likelihood of meeting one or more of these stated goals: to improve function, minimize loss of function, or decrease risk of injury and disease.

~~(b)~~ (c) For purposes of this article and section, "rehabilitation services" includes those services which are designed to remediate patient's condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status. Rehabilitative services include by illustration and not limitation diagnostic testing, assessment, monitoring or treatment of the following conditions individually or in a combination:

(1) Stroke;

(2) Spinal cord injury;

(3) Congenital deformity;

(4) Amputation;

(5) Major multiple trauma;

(6) Fracture of femur;

(7) Brain injury;

(8) Polyarthritis, including rheumatoid arthritis;

(9) Neurological disorders, including, but not limited to, multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy and Parkinson's disease;

(10) Cardiac disorders, including, but not limited to, acute myocardial infarction, angina pectoris, coronary arterial insufficiency, angioplasty, heart transplantation, chronic arrhythmias, congestive heart failure, valvular heart disease;

(11) Burns;

(12) Orthopedic Disorders;

(13) Chronic Diseases including, but not limited to, diabetes, hypertension and obesity;

(14) Fall prevention and treatment;

~~(c)~~ (d) Rehabilitative services includes care rendered by any of the following:

(1) A hospital duly licensed by the State of West Virginia that meets the requirements for rehabilitation hospitals as

described in Section 2803.2 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(2) A distinct part rehabilitation unit in a hospital duly licensed by the State of West Virginia. The distinct part unit must meet the requirements of Section 2803.61 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(3) A hospital duly licensed by the State of West Virginia which meets the requirements for cardiac rehabilitation as described in Section 35-25, Transmittal 41, dated August, 1989, as promulgated by the U.S. Health Care Financing Administration.

(4) Physical Therapists, Occupational Therapists and Speech Language Pathologists; (qualified health care professionals currently authorized under federal law (*42 C.F.R. § 484.4*).

~~(d)~~ (e) Rehabilitation services do not include services for mental health, chemical dependency, vocational rehabilitation, long-term maintenance or custodial services.

~~(e)~~ (f) A policy, provision, contract, plan or agreement may apply to rehabilitation services the same deductibles, coinsurance and other limitations as apply to other covered services.

§33-25A-81. Copayments and coinsurance.

"Copayment" means a specific dollar amount or percentage not

to exceed twenty-five percent of covered charges, except as otherwise provided for by statute, that the subscriber must pay upon receipt of covered health care services and which is set at an amount or percentage consistent with allowing subscriber access to health care services.

(a) Copayments in health benefit plans may not exceed the following amounts:

(1) Preventive services, $30;

(2) Primary care provider office visit, including physical, occupational and speech therapists, $30;

(3) Specialist physician office visit, $75;

(4) Emergency room visit, $100;

(5) Outpatient surgery, $500;

(6) Inpatient admission, $500 per day up to a maximum of $2,500 per admission;

(7) Magnetic resonance imaging, computerized axial tomography and positron emission tomography, $100;

(8) For any other services and supplies, the copayment is to be determined so that the carrier insures seventy-five percent or more of the aggregate risk for the service or supply to which the copayment is applied.

(b) Network copayment may not be applied to any service or supply to which network coinsurance is applied.

(c) "Family out-of-pocket limit" means the maximum dollar amount that a family shall pay in combination as copayment, deductible and coinsurance for network covered services and supplies in a calendar, contract or policy year.

(d) "Individual out-of-pocket limit" means the maximum dollar amount that a covered person shall pay as copayment, deductible and coinsurance for services and supplies provided by network providers in a calendar, contract or policy year.

(e) "Network coinsurance" means the percentage of the contractual fee of the network provider for covered services and supplies specified in the contract between the provider and the carrier that must be paid by the covered person, under the health benefit plan, subject to network deductible and network out-of-pocket limit.

(f) All amounts paid as copayment, coinsurance and deductible count toward the out-of-pocket limit, and may not be excluded because of the nature of the service rendered, the illness or condition being treated, or for any other reason, except carriers may, provided the terms of the health benefit plan so state, elect to exclude from the out-of-pocket limit the cost sharing associated with prescription drug coverage, whether provided as part of the health benefit plan or as a rider.

§33-25A-31. Policies discriminating among health care providers.

Notwithstanding any other provisions of law, when any health insurance policy, health care services plan or other contract provides for the payment of medical expenses, benefits or procedures, ~~such~~ the policy, plan or contract shall be construed to include payment to all health care providers including, but not limited to, medical physicians, osteopathic physicians, podiatric physicians, chiropractic physicians, physical therapists, occupational therapists, midwives, ~~and~~ nurse practitioners and their licensed assistants, who provide medical services, benefits or procedures which are within the scope of each respective provider's license. Any limitation or condition placed upon services, diagnoses or treatment by, or payment to any particular type of licensed provider shall apply equally to all types of licensed providers without unfair discrimination as to the usual and customary treatment procedures of any of the aforesaid providers.

ARTICLE 28. INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS.

§33-28-8. Policies discriminating among health care providers.

Notwithstanding any other provisions of law, when any health insurance policy, health care services plan or other contract provides for the payment of medical expenses, benefits or procedures, the policy, plan or contract shall be construed to

include payment to all health care providers including, but not limited to, medical physicians, osteopathic physicians, podiatric physicians, chiropractic physicians, physical therapists, occupational therapists, midwives, nurse practitioners and their licensed assistants, who provide medical services, benefits or procedures which are within the scope of each respective provider's license. Any limitation or condition placed upon services, diagnoses or treatment by, or payment to any particular type of licensed provider shall apply equally to all types of licensed providers without unfair discrimination as to the usual and customary treatment procedures of any of the aforesaid providers.

§33-28-9. Third party reimbursement for rehabilitation services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, 2014, provide as benefits to all subscribers and members coverage for rehabilitation services as hereinafter set forth, unless rejected by the insured.

(b) *Medically necessary rehabilitation services.* -- Rehabilitation, as part of an individual’s health care, is considered medically necessary as determined by the qualified health care provider based on the results of an evaluation and when provided for the purpose of preventing, minimizing or eliminating

impairments, activity limitations or participation restrictions. Rehabilitation services are delivered throughout the episode of care by the qualified health care provider or under his or her direction and supervision; requires the knowledge, clinical judgment, and abilities of the qualified health care provider; takes into consideration the potential benefits and harms to the patient/client; and is not provided exclusively for the convenience of the patient/client. Rehabilitation services are provided using evidence of effectiveness and applicable standards of practice and is considered medically necessary if the type, amount and duration of services outlined in the plan of care increase the likelihood of meeting one or more of these stated goals: to improve function, minimize loss of function, or decrease risk of injury and disease.

(c) For purposes of this article and section, "rehabilitation services" includes those services which are designed to remediate patient's condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status. Rehabilitative services include by illustration and not limitation diagnostic testing, assessment, monitoring or treatment of the following conditions individually or in a combination:

(1) Stroke;

(2) Spinal cord injury;

(3) Congenital deformity;

(4) Amputation;

(5) Major multiple trauma;

(6) Fracture of femur;

(7) Brain injury;

(8) Polyarthritis, including rheumatoid arthritis;

(9) Neurological disorders, including, but not limited to, multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy and Parkinson's disease;

(10) Cardiac disorders, including, but not limited to, acute myocardial infarction, angina pectoris, coronary arterial insufficiency, angioplasty, heart transplantation, chronic arrhythmias, congestive heart failure, valvular heart disease;

(11) Burns;

(12) Orthopedic Disorders;

(13) Chronic Diseases including, but not limited to, diabetes, hypertension and obesity;

(14) Fall prevention and treatment;

(d) Rehabilitative services includes care rendered by any of the following:

(1) A hospital duly licensed by the State of West Virginia that meets the requirements for rehabilitation hospitals as described in Section 2803.2 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing

Administration;

(2) A distinct part rehabilitation unit in a hospital duly licensed by the State of West Virginia. The distinct part unit must meet the requirements of Section 2803.61 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(3) A hospital duly licensed by the State of West Virginia which meets the requirements for cardiac rehabilitation as described in Section 35-25, Transmittal 41, dated August, 1989, as promulgated by the U.S. Health Care Financing Administration.

(4) Physical Therapists, Occupational Therapists and Speech Language Pathologists; (qualified health care professionals currently authorized under federal law (*42 C.F.R. § 484.4*).

(e) Rehabilitation services do not include services for mental health, chemical dependency, vocational rehabilitation, long-term maintenance or custodial services.

(f) A policy, provision, contract, plan or agreement shall apply to rehabilitation services the same deductibles, coinsurance and other limitations as apply to other covered services.

NOTE: The purpose of this bill is to create the West Virginia Fair Health Insurance Act of 2014. The bill defines "illusionary benefit" to require benefits to cover at least seventy-five percent of health care service. It establishes reasonable copays among common insurance needs. It prevents insurance companies from

discriminating against licensed health care practitioners to whom they will pay for a covered service. The bill prevents insurance companies from arbitrarily defining medically necessary rehabilitation services to avoid making payment for a covered service or for a service that should be covered. The bill makes physical therapy and rehabilitation services a mandated covered service for any health insurance plan. And, the bill increases the monetary criminal penalty for insurance companies that violate any provisions of the chapter.

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

§33-1-22, §33-15-22, §33-16-18, §33-16D-17, §33-16D-18, §33-16D-19, §33-24-7m, §33-25-8j, §33-25A-8l, §33-28-8 and §33-28-9 are new; therefore, strike-throughs and underscoring have been omitted.