WEST VIRGINIA LEGISLATURE

2019 REGULAR SESSION

Introduced

House Bill 2380

BY DELEGATE FLEISCHAUER

[Introduced January 14, 2019; Referred

to the Committee on Banking and Insurance then

Health and Human Resources.]

A BILL to amend and reenact §33-15-2a and §33-15-4, of the Code of West Virginia, 1931, as amended; to amend said code by adding thereto three new sections designated §33-15-4s, §33-15-20a, and §33-15-22, all related to defining surprise bills and health care providers, adding new disclosure requirements for health care providers, hospitals, and insurers, adding the requirement that insurers develop an access plan for consumers, and establishing how surprise bills are to be handled in certain circumstances.

Be it enacted by the Legislature of West Virginia:

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-2a. Definitions.

For purposes of this section and §33-15-2b, §33-15-2c, §33-15-2d, §33-15-2e, §33-15-2f, §33-15-2g, and §33-15-4e:

(a) “Accident and sickness insurance coverage” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy of certificate, hospital or medical service plan contract, or health maintenance organization contract offered by an insurer, but does not include short-term limited duration insurance.

(b) “Bona fide Association” means an association which has been actively in existence for at least five years; has been formed and maintained in good faith for purposes other than obtaining insurance; does not condition membership in the association on any health status-related factor relating to an individual; makes accident and sickness insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member; does not make accident and sickness insurance coverage offered through the association available other than in connection with a member of the association; and meets any additional requirements as may be set forth in this chapter or by rule.

(c) “COBRA continuation provision” means any of the following:

(1) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines;

(2) Part 6 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, other than Section 609 of such act; or

(3) Title XXII of the Public Health Service Act.

(d) “Creditable coverage” means, with respect to an individual, coverage of the individual under any of the following:

(1) A group health plan;

(2) Accident and sickness insurance coverage;

(3) Part A or Part B of Title XVIII of the Social Security Act;

(4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

(5) Chapter 55 of Title 10 of the United States Code;

(6) A medical care program of the Indian Health Service or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under Chapter 89 of Title 5 of the United States Code;

(9) A public health plan (as defined in federal regulations); or

(10) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

The term “creditable coverage” does not include those benefits set forth in §33-15-2g of this code.

(e) “Eligible individual” means an individual:

(1) For whom, as of the date on which the individual seeks coverage, the aggregate period of creditable coverage is 18 months or more and whose most recent prior creditable coverage was under a group health plan, governmental plan (as defined in section 3(32) of the Employee Retirement Income Security Act of 1974), church plan (as defined in section 3(33) of the Employee Retirement Income Security Act of 1974), or accident and sickness insurance coverage offered

in connection with any such plan;

(2) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, or state plan under Title XIX of such act (or any successor program), and does not have other accident and sickness insurance coverage;

(3) With respect to whom the most recent prior creditable coverage was not terminated as a result of fraud, intentional misrepresentation of material fact under the terms of the coverage, or nonpayment of premium;

(4) Who did not turn down an offer of continuation of coverage under a COBRA continuation provision or under a similar state program if it was offered; and

(5) Who, if the individual elected such continuation coverage, has exhausted that coverage under the COBRA continuation provision or similar state program.

(f) "Group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care to employees and their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement or otherwise.

(g) "Health care provider" means a person, partnership, corporation, facility, hospital or institution licensed, certified or authorized by law to provide professional health care service in this state to an individual during the individual's medical treatment, or behavioral health care, treatment or confinement.

~~(g)~~ (h) "Health status-related factor" means an individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, and evidence of insurability (including conditions arising out of acts of domestic violence) or disability.

~~(h)~~ (i) "Higher-level coverage" means a policy form for which the actuarial value of the benefits under the coverage is at least 15 percent greater than the actuarial value of lower-level coverage offered by the insurer in this state, and the actuarial value of the benefits under the

coverage is at least 100 percent but not greater than 120 percent of a weighted average.

~~(i)~~ (j) "Individual market" means the market for accident and sickness insurance coverage offered to individuals other than in connection with a group health plan.

~~(j)~~ (k) "Insurer" means an entity licensed by the commissioner to transact accident and sickness insurance in this state and subject to this chapter, but does not include a group health plan or short term limited duration insurance.

~~(k)~~ (l) "Lower-level coverage" means a policy form for which the actuarial value of the benefits under the coverage is at least 85 percent but not greater than 100 percent of a weighted average.

~~(l)~~ (m) "Medical care" means amounts paid for, or paid for insurance covering, the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, including the amounts paid for transportation primarily for and essential to such care.

~~(m)~~ (n) "Network plan" means accident and sickness insurance coverage of an insurer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a definite set of providers under contract with the insurer.

~~(n)~~ (o) "Preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

(p) "Surprise bill" means an invoice for health care services, other than emergency services, received by a patient in one of three circumstances:

(1) An insured receives services from an out-of-network health care provider at an in-network hospital or ambulatory surgery center, where a participating health care provider is unavailable or an out-of-network health care provider renders services without the patient's

knowledge.

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

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

~~(e)~~ (g) "Weighted average" means the average actuarial value of the benefits provided by all the accident and sickness insurance coverage issued (as elected by the insurer) either by that insurer or by all insurers in this state in the individual accident and sickness market during the previous year (not including coverage issued under this section), weighted by enrollment for the different coverage.

§33-15-4. Required policy provisions.

Except as provided in §33-15-6 of this code, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this section in the words in which the same appear in this section: *Provided,* That the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(a) A provision as follows:

"Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions."

(b) A provision as follows:

"Time Limit on Certain Defenses:

(1) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period."

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of §33-15-5(a), §33-15-5(b), §33-15-5(c), §33-15-5(d),and §33-15-5(e) of this code in the event of misstatement with respect to age or occupation or other insurance. A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (i) until at least age 50, or (ii) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "Incontestable":

"After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(2) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

(c) A provision as follows:

"Grace Period: A grace period of _____ (insert a number not less than 'seven' for weekly premium policies, '10' for monthly premium policies and '31' for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force."

(d) A provision as follows:

"Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, as subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy: *Provided,* That if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer, or lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement."

(e) A provision as follows:

"Notice of Claim: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer."

In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

"Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he <u>or she</u> shall, at least

once in every six months after having given notice of claim give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability, in whole or in part, by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given."

(f) A provision as follows:

"Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made."

(g) A provision as follows:

"Proof of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required."

(h) A provision as follows:

"Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of

due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid _____ (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof."

(i) A provision as follows: "Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured."

The following provisions, or either of them, may be included with the foregoing provisions at the option of the insurer:

"If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $_____ (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment."

"Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person."

(j) A provision as follows:

"Physical Examinations and Autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law."

(k) A provision as follows:

"Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished."

(l) A provision as follows:

"Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy."

The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

(m) A provision as follows:

An access plan that includes the following components:

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

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

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

(4) The insurer's process for making available in consumer-friendly language the criteria it has used to build its provider network, including information about the breadth of the network

and the criteria used to select or rank providers, which must be made available through the health carrier's on-line and in-print provider directories;

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

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

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

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

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

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

(11) The insurer's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory

services at their participating hospitals; and

(12) Any other information required by the commissioner to determine compliance with the provisions of this article.

§33-15-4s. Required disclosures:

(a) Health care providers must:

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

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

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

(c) Hospitals must post the following information on their website:

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

(2) The health plans in which they participate;

(3) A warning that: (i) Charges for health care provider's who provide services in the hospital are not part of the hospital's charges; and (ii) health care providers who provide services in the hospital may not be in the same networks as the hospital; and

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

(5) In addition, in the registration and admission materials provided in advance of the provision of nonemergency services, hospitals must: (i) Advise patients to check with the health care provider arranging their services to determine the name, address and phone number of any other health care provider involved in the patient's care, and whether any employed or contracted specialty physicians are expected to participate in the patient's care; and (ii) provide patients with information regarding how they can timely determine the health plans in which the health care providers participate.

(d) Health Plans shall:

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

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

§33-15-20a. Insurers requirements related to in-network and out of network providers.

(a) An insurer shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits from a nonparticipating provider, or shall make other arrangements acceptable to the commissioner when:

(1) The insurer has a sufficient network, but has determined that it does not have a type of provider available to provide the covered benefit to the covered person or it does not have a participating provider available to provide the covered benefit without unreasonable travel or delay; or

(2) The insurer has an insufficient number or type of participating providers available to provide the covered benefit to the covered person without unreasonable travel or delay.

(b) The insurer shall specify the process a covered person may use to request access to

obtain a covered benefit from a nonparticipating out of network provider as provided in §33-15-20a(a) of this code when:

(1) The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and

(2) The insurer:

(i) Does not have a network provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or

(ii) Cannot provide reasonable access to a network provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay.

(c) The insurer shall treat the services the covered person receives from a nonnetwork provider pursuant to §33-15-20a(b)(2) of this code as if the services were provided by a network provider.

(d) The process described in this section must ensure that requests to obtain a covered benefit from a nonparticipating provider are addressed in a timely fashion appropriate to the covered person's condition.

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

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

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

NOTE: The purpose of this bill is to define surprise bills, to protect consumers from surprise bills in certain circumstances, to require additional disclosures by health care providers, hospitals and insurers and to require insurers to develop an access plan with certain components for consumers, and establishing how surprise bills are to be handled in certain circumstances.

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