

# **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.]

1 A BILL to amend and reenact §33-15-2a and §33-15-4, of the Code of West Virginia, 1931, as  
2 amended; to amend said code by adding thereto three new sections designated §33-15-  
3 4s, §33-15-20a, and §33-15-22, all related to defining surprise bills and health care  
4 providers, adding new disclosure requirements for health care providers, hospitals, and  
5 insurers, adding the requirement that insurers develop an access plan for consumers, and  
6 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.**

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

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

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

17 (c) "COBRA continuation provision" means any of the following:

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

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

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

23 (d) "Creditable coverage" means, with respect to an individual, coverage of the individual  
24 under any of the following:

25 (1) A group health plan;

26 (2) Accident and sickness insurance coverage;

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

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

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

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

32 (7) A state health benefits risk pool;

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

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

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

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

38 (e) "Eligible individual" means an individual:

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

44 in connection with any such plan;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

96 knowledge.

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

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

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

**§33-15-4. Required policy provisions.**

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

9 (a) A provision as follows:

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

14 (b) A provision as follows:

15 "Time Limit on Certain Defenses:

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

20 The foregoing policy provision shall not be so construed as to affect any legal requirement  
21 for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the  
22 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  
23 the event of misstatement with respect to age or occupation or other insurance. A policy which  
24 the insured has the right to continue in force subject to its terms by the timely payment of premium  
25 (i) until at least age 50, or (ii) in the case of a policy issued after age 44, for at least five years  
26 from its date of issue, may contain in lieu of the foregoing the following provision (from which the  
27 clause in parentheses may be omitted at the insurer's option) under the caption "Incontestable":

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

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

35 (c) A provision as follows:

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

40 (d) A provision as follows:

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

54 (e) A provision as follows:

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

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

64 “Subject to the qualifications set forth below, if the insured suffers loss of time on account  
65 of disability for which indemnity may be payable for at least two years, he or she shall, at least



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

73 (f) A provision as follows:

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

80 (g) A provision as follows:

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

89 (h) A provision as follows:

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

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

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

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

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

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

117 (j) A provision as follows:

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

122           (k) A provision as follows:

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

127           (l) A provision as follows:

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

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

134           (m) A provision as follows:

135           An access plan that includes the following components:

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

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

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

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

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

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

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

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

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

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

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

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

170 services at their participating hospitals; and

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

**§33-15-4s. Required disclosures:**

1 (a) Health care providers must:

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 must inform the patient, prior to providing nonemergency  
6 services that: (i) The actual or estimated amount for the service is available upon request, and (ii)  
7 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, must 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) Hospitals must post the following information on their website:

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

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

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

20 (4) 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 (5) In addition, in the registration and admission materials provided in advance of the  
24 provision of nonemergency services, hospitals must: (i) 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 (ii) 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.

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

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

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

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

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

11 obtain a covered benefit from a nonparticipating out of network provider as provided in §33-15-  
12 20a(a) of this code when:

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

15 (2) The insurer:

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

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

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

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

**§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 will 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.

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.