

WEST VIRGINIA LEGISLATURE

2021 REGULAR SESSION

Committee Substitute

for

House Bill 2005

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PINSON, AND BURKHAMMER

[Originating in the Committee on Health and Human
Resources; Reported on February 11, 2021]

1 A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section,
2 designated §16-29B-6; to amend said code by adding thereto a new article, designated
3 §33-60-1, §33-60-2, §33-60-3, §33-60-4, §33-60-5, §33-60-6, §33-60-7, §33-60-8, and
4 §33-60-9; to amend said code by adding thereto a new article, designated §33-61-1, and
5 §33-61-2; and to amend said code by adding thereto a new article, designated §47-29-1,
6 all relating to health care costs generally; requiring reports to the health care authority;
7 providing for the regulation of out-of-state healthcare providers and non-network facility
8 based providers; providing for the disclosures of a healthcare facility and the publication
9 of a carrier's network; defining the responsibilities of a carrier inadvertent to out-of-state
10 network services; providing for binding arbitration in the event of payment disputes;
11 providing for healthcare savings cost calculations, violations and legislative rules;
12 providing for price transparency and a publication of prices; and providing a cost of
13 healthcare appointment prices.

Be it enacted by the Legislature of West Virginia:

CHAPTER 16. PUBLIC HEALTH.

ARTICLE 29B. HEALTH CARE AUTHORITY.

§16-29B-6. Review of nonprofit status of hospitals.

1 A summary of every contract or an amendment to an existing contract for the payment of
2 patient care services between a purchaser or third party payor and a hospital shall be filed by the
3 hospital to the health care authority.

CHAPTER 33. INSURANCE.

ARTICLE 60. OUT-OF-NETWORK CONSUMER PROTECTION, TRANSPARENCY, **COST CONTAINMENT AND ACCOUNTABILITY ACT.**

§33-60-1. Definitions.

1 As used in this article:

2 “Carrier means” an entity that contracts or offers to contract to provide, deliver, arrange
3 for, pay for, or reimburse any of the costs of health care services under a health benefits plan,
4 including: an insurance company authorized to issue health benefits plans; a health maintenance
5 organization; a health, hospital, or medical service corporation; a multiple employer welfare
6 arrangement; the Public Employees Insurance Benefits Program; or any other entity providing a
7 health benefits plan. Except as provided under the provisions of this article, “carrier” shall not
8 include any other entity providing or administering a self-funded health benefits plan.

9 “Commissioner” means the Commissioner of the Offices of the Insurance Commissioner.

10 “Covered person” means a person on whose behalf a carrier is obligated to pay health
11 care expense benefits or provide health care services.

12 “Emergency or urgent basis” means those health care services that are provided for a
13 condition of recent onset and sufficient severity, including, but not limited to, severe pain, that
14 would lead a prudent layperson, possessing an average knowledge of medicine and health, to
15 believe that his or her condition, sickness, or injury is of such a nature that failure to obtain
16 immediate medical care could result in:

17 (A) Placing the patient’s health in serious jeopardy;

18 (B) Serious impairment to bodily functions; or

19 (C) Serious dysfunction of any bodily organ or part.

20 “Facility-based provider” means a physician or provider who provides health care services
21 to patients of a health care facility.

22 “Health benefits plan” means a benefits plan which pays or provides hospital and medical
23 expense benefits for covered services, and is delivered or issued for delivery in this state by or
24 through a carrier. For the purposes of this article, “health benefits plan” shall not include the
25 following plans, policies or contracts: Medicaid, Medicare, Medicare Advantage, accident only,
26 credit, disability, long-term care, TRICARE supplement coverage, coverage arising out of a

27 workers' compensation or similar law, automobile medical payment insurance, personal injury
28 protection insurance issued; a dental plan; and hospital confinement indemnity coverage.

29 "Health care facility" means a hospital, an ambulatory surgery facility, or any other free-
30 standing ambulatory care center.

31 "Health care professional" means an individual, acting within the scope of his or her
32 licensure, certification or registration, who provides a covered service in a health benefits plan.

33 "Health care provider" or "provider" means a health care professional or health care facility.

34 "Hospital" means a facility licensed pursuant to §16-5B-1 et seq. of this code and any
35 acute-care facility operated by the state government that primarily provides inpatient diagnostic,
36 treatment or rehabilitative services to injured, disabled or sick persons under the supervision of
37 physicians and includes psychiatric hospitals.

38 "Inadvertent out-of-network services" means health care services that are: covered under
39 a health benefits plan that provides a network; and provided by an out-of-network health care
40 provider in the event that a covered person utilizes an in-network health care facility for covered
41 health care services and, for any reason, in-network health care services are unavailable in that
42 facility. "Inadvertent out-of-network services" shall include laboratory testing ordered by an in-
43 network health care provider and performed by an out-of-network bio-analytical laboratory.

44 "Knowingly, voluntarily, and specifically selected an out-of-network provider" means that
45 a covered person chose the services of a specific provider, with full knowledge that the provider
46 is out-of-network with respect to the covered person's health benefits plan, under circumstances
47 that indicate that covered person had the opportunity to be serviced by an in-network provider,
48 but instead selected the out-of-network provider. Disclosure by a provider of network status shall
49 not render a covered person's decision to proceed with treatment from that provider a choice
50 made "knowingly" pursuant to this definition.

51 "Medical necessity" or "medically necessary" means or describes a health care service
52 that a health care provider, exercising his or her prudent clinical judgment, would provide to a

53 covered person for the purpose of evaluating, diagnosing, or treating an illness, injury, disease,
54 or its symptoms and that is: in accordance with the generally accepted standards of medical
55 practice; clinically appropriate, in terms of type, frequency, extent, site, and duration, and
56 considered effective for the covered person's illness, injury, or disease; not primarily for the
57 convenience of the covered person or the health care provider; and not more costly than an
58 alternative service or sequence of services at least as likely to produce equivalent therapeutic or
59 diagnostic results as to the diagnosis or treatment of that covered person's illness, injury, or
60 disease.

61 "Medicare" means the federal Medicare program established pursuant to Pub.L.89-97 (42
62 U.S.C. s.1395 et seq.).

63 "Office" means the Office of the Insurance Commissioner.

64 "Self-funded health benefits plan" or "self-funded plan" means a self-insured health
65 benefits plan governed by the provisions of the federal Employee Retirement Income Security Act
66 of 1974, 29 U.S.C. s.1001 et seq.

67 "Usual and customary rate" means the median of the contracted rates recognized by the
68 carrier as the total maximum payment, to include the cost-sharing amount imposed for such item
69 or service and the amount to be paid by the carrier for the same or a similar item or service that
70 is provided by a provider in the same or similar specialty and provided in the geographic region
71 in which the item or service is furnished.

§33-60-2. Non-Network Facility-Based Providers.

1 (a) Except as provided by subsection (c), a carrier shall pay for a covered health care
2 service provided by a non-network physician or provider who is a facility-based provider at the
3 usual and customary rate or at an agreed rate if the provider performed the services at a health
4 care facility that is a network provider. The carrier shall make a payment required by this
5 subsection directly to the physician or provider not later than, as applicable:

6 (1) The 30th day after the date the carrier receives a clean electronic claim for those
7 services that includes all information necessary for the carrier to pay the claim; or

8 (2) The 45th day after the date the carrier receives a clean nonelectronic claim for those
9 services that includes all information necessary for the carrier to pay the claim.

10 (b) Except as provided by subsection (c), a non-network facility-based provider, or a
11 person asserting a claim as an agent or assignee of the provider, may not bill an enrollee receiving
12 a health care service described by subsection (a) in, and the enrollee does not have financial
13 responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible
14 under the enrollee's health care plan that:

15 (1) Is based on:

16 (A) The amount initially determined payable by the carrier; or

17 (B) If applicable, a modified amount as determined under the carrier's internal appeal
18 process; and

19 (2) Is not based on any additional amount determined to be owed to the provider under
20 this article.

21 (c) This section does not apply to a nonemergency health care or medical service:

22 (1) That an enrollee elects to receive in writing in advance of the service with respect to
23 each non-network physician or provider providing the services; and

24 (2) For which a non-network physician or provider, before providing the service, provides
25 a complete written and verbal disclosure to the enrollee that:

26 (A) Explains that the physician or provider does not have a contract with the enrollee's
27 health benefit plan;

28 (B) Discloses projected amounts for which the enrollee may be responsible; and

29 (C) Discloses the circumstances under which the enrollee would be responsible for these
30 amounts.

§33-60-3. Disclosures by health care facility.

1 (a) A health care facility shall post on the facility's website:

2 (1) The health benefits plans in which the facility is a participating provider;

3 (2) A statement that:

4 (A) Physician services provided in the facility are not included in the facility's charges;

5 (B) Physicians who provide services in the facility may or may not participate with the
6 same health benefits plans as the facility;

7 (C)The covered person should check with the physician arranging for the facility services
8 to determine the health benefits plans in which the physician participates; and

9 (D) The covered person should contact their carrier for further consultation on those costs;

10 (3) As applicable, the name, mailing address, and telephone number of the hospital-based
11 physician groups that the facility has contracted with to provide services including, but not limited
12 to, anesthesiology, pathology, and radiology; and

13 (4) As applicable, the name, mailing address, and telephone number of physicians
14 employed by the facility and whose services may be provided at the facility, and the health benefits
15 plans in which they participate.

16 (b) If, between the time the notice required is provided to the covered person and the time
17 the procedure takes place, the network status of the facility changes as it relates to the covered
18 person's health benefits plan, the facility shall notify the covered person promptly.

19 (c) The Office of the Insurance Commissioner shall specify in further detail the content
20 and design of the disclosure form and the manner in which the form shall be provided.

§33-60-4. Publication of a carrier's network.

1 (a) A carrier shall update its website within 30 days of the addition or termination of a
2 provider from the carrier's network or a change in a physician's affiliation with a facility, provided
3 that in the case of a change in affiliation the carrier has had notice of such change.

4 (b) With respect to out-of-network services, for each health benefits plan offered, a carrier
5 shall provide a covered person with:

6 (1) A clear description of the plan's out-of-network health care benefits, including the
7 methodology used by the entity to determine the allowed amount for out-of-network services;

8 (2) The allowed amount the plan will reimburse under that methodology and, in situations
9 in which a covered person requests allowed amounts associated with a specific Current
10 Procedural Terminology code, the portion of the allowed amount the plan will reimburse and the
11 portion of the allowed amount that the covered person will pay, including an explanation that the
12 covered person will be required to pay the difference between the allowed amount as defined by
13 the carrier's plan and the charges billed by an out-of-network provider;

14 (3) Examples of anticipated out-of-pocket costs for frequently billed out-of-network
15 services;

16 (4) Information in writing and through an internet website that reasonably permits a
17 covered person or prospective covered person to calculate the anticipated out-of-pocket cost for
18 out-of-network services in a geographical region or zip code based upon the difference between
19 the amount the carrier will reimburse for out-of-network services and the usual and customary
20 cost of out-of-network services;

21 (5) Information in response to a covered person's request, concerning whether a health
22 care provider is an in-network provider;

23 (6) Other information as the commissioner determines appropriate and necessary to
24 ensure that a covered person receives sufficient information necessary to estimate their out-of-
25 pocket cost for an out-of-network service and make a well-informed health care decision; and

26 (7) Access to a telephone hotline for consumers to call with questions about network status
27 and out-of-pocket costs.

28 (c) If a carrier authorizes a covered health care service to be performed by an in-network
29 health care provider with respect to any health benefits plan, and the provider status changes to
30 out-of-network before the authorized service is performed, the carrier shall notify the covered
31 person that the provider is no longer in-network as soon as practicable. If the carrier fails to

32 provide the notice at least 30 days prior to the authorized service being performed, the covered
33 person's financial responsibility shall be limited to the financial responsibility the covered person
34 would have incurred had the provider been in-network with respect to the covered person's health
35 benefits plan and the carrier shall be required to pay the health care provider the in-network rate
36 in effect prior to the change in provider status.

37 (d) A carrier shall incorporate into the Explanation of Benefits, and all reimbursement
38 correspondence to the consumer and the provider, clear and concise notification that inadvertent
39 and involuntary out-of-network charges are not subject to balance billing above and beyond the
40 financial responsibility incurred under the terms of the contract for in-network service. Any attempt
41 by the provider to collect, bill, or invoice funds should be promptly reported to the carrier's
42 customer service division at the phone number that the carrier shall provide on the Explanation
43 of Benefits and all reimbursement correspondence to the consumer.

44 (e) A carrier shall include in the carrier's annual public regulatory filings, the number of
45 claims submitted by health care providers to the carrier which are denied or down coded by the
46 carrier and the reason for the denial or down coding determination.

§33-60-5. Responsibilities of carrier relative to inadvertent out-of-network services.

1 (a) With respect to a carrier, if a covered person receives inadvertent out-of-network
2 services, or services at an in-network or out-of-network health care facility on an emergency or
3 urgent basis, the carrier shall ensure that the covered person incurs no greater out-of-pocket
4 costs than the covered person would have incurred with an in-network health care provider for
5 covered services. The out-of-network provider shall not bill the covered person, except for
6 applicable deductible, copayment, or coinsurance amounts that would apply if the covered person
7 utilized an in-network health care provider for the covered services.

8 (b) (1) With respect to inadvertent out-of-network services, or services at an in-network or
9 out-of-network health care facility on an emergency or urgent basis, benefits provided by a carrier
10 that the covered person receives for health care services shall be assigned to the out-of-network

11 health care provider, which shall require no action on the part of the covered person. Once the
12 benefit is assigned as provided in this subsection:

13 (A) Any reimbursement paid by the carrier shall be paid directly to the out-of-network
14 provider; and

15 (B) The carrier shall provide the out-of-network provider with a written remittance of
16 payment that specifies the proposed reimbursement and the applicable deductible, copayment,
17 or coinsurance amounts owed by the covered person.

18 (c) If inadvertent out-of-network services or services provided at an in-network or out-of-
19 network health care facility on an emergency or urgent basis are performed in accordance with
20 subsection (a) of this section, the out-of-network provider may bill the carrier for the services
21 rendered. The carrier may pay the billed amount or the carrier shall determine within 20 days from
22 the date of the receipt of the claim for the services whether the carrier considers the claim to be
23 excessive, and if so, the carrier shall notify the provider of this determination within 20 days of the
24 receipt of the claim. If the carrier provides this notification, the carrier and the provider shall have
25 30 days from the date of this notification to negotiate a settlement. The carrier may attempt to
26 negotiate a final reimbursement amount with the out-of-network health care provider which differs
27 from the amount paid by the carrier pursuant to this subsection. If there is no settlement reached
28 after the 30 days, the carrier shall pay the provider their final offer for the services. If the carrier
29 and provider cannot agree on the final offer as a reimbursement rate for these services, the carrier
30 or provider shall initiate binding arbitration within 30 days of the final offer.

§33-60-6. Payment disputes, binding arbitration.

1 If attempts to negotiate reimbursement for services provided by an out-of-network health
2 care provider do not result in a resolution of the payment dispute, as provided in §30-60-5, and
3 the difference between the carrier's and the provider's or facility's final offers is not less than
4 \$1,000, the carrier or out-of-network health care provider shall initiate binding arbitration to

5 determine payment for the services, as provided in Division BB, Title 1, Section 103 of the 'No
6 Surprises Act' of 2020.

§33-60-7. Notice of protections provided.

1 (a) A carrier shall provide a written notice, in a form and manner to be prescribed by the
2 commissioner, to each covered person of the protections provided to covered persons pursuant
3 to this article. The notice shall include information on how a consumer can contact the office to
4 report and dispute an out-of-network charge. The notice required pursuant to this section shall be
5 posted on the carrier's website.

6 (b) The commissioner shall provide a notice on the office's website containing information
7 for consumers relating to the protections provided by this article, information on how consumers
8 can report and file complaints with the office relating to any out-of-network charges, and
9 information and guidance for consumers regarding arbitrations.

§33-60-8. Calculation of savings; reports.

1 A carrier shall calculate, as part of rate filings required to be filed under West Virginia law,
2 the savings that result from a reduction in out-of-network claims payments pursuant to the
3 provisions of this article. The office shall include that information in the information provided on
4 the office's website.

§33-60-9. Violations, inducements.

1 (a) It shall be a violation of this article if an out-of-network health care provider, directly or
2 indirectly related to a claim, knowingly waives, rebates, gives, pays, or offers to waive, rebate,
3 give or pay all or part of the deductible, copayment, or coinsurance owed by a covered person
4 pursuant to the terms of the covered person's health benefits plan as an inducement for the
5 covered person to seek health care services from that provider. As the commissioner shall
6 prescribe by legislative rule, a pattern of waiving, rebating, giving or paying all or part of the
7 deductible, copayment or coinsurance by a provider shall be considered an inducement for the
8 purposes of this subsection.

9 (b) This section shall not apply to any waiver, rebate, gift, payment, or offer that falls within
10 a safe harbor under federal laws related to fraud and abuse concerning patient cost-sharing,
11 including, but not limited to, anti-kickback, self-referral, false claims, and civil monetary penalties,
12 including any advisory opinions issued by the Centers for Medicare and Medicaid Services or the
13 Office of Inspector General pertaining to those laws.

14 (c) The provisions of this article shall be enforced by the Office of the Insurance
15 Commissioner.

§33-60-10. Legislative Rules.

1 The Commissioner of Insurance may adopt legislative rules in order to effectuate the
2 purposes of this article.

ARTICLE 61. PRICE TRANSPARENCY.

§33-61-1. Definitions.

1 As used in this article, the term:

2 (1) "Covered person" means an individual who is covered under a health benefit policy.

3 (2) "Emergency services" means those health care services that are provided for a
4 condition of recent onset and sufficient severity, including, but not limited to, severe pain, that
5 would lead a prudent layperson, possessing an average knowledge of medicine and health, to
6 believe that his or her condition, sickness, or injury is of such a nature that failure to obtain
7 immediate medical care could result in:

8 (A) Placing the patient's health in serious jeopardy;

9 (B) Serious impairment to bodily functions; or

10 (C) Serious dysfunction of any bodily organ or part.

11 (3) "Health benefit policy" or "policy" means any individual or group plan, policy, or contract
12 for health care services issued, delivered, issued for delivery, executed, or renewed in this state,
13 including, but not limited to, those contracts executed by the state on behalf of state employees
14 under §5-16-1 et seq. of this code.

15 (4) “Health care provider” or “provider” means any physician, dentist, podiatrist,
16 pharmacist, optometrist, psychologist, clinical social worker, advanced practice nurse, registered
17 optician, licensed professional counselor, physical therapist, marriage and family therapist,
18 chiropractor, athletic trainer, occupational therapist, speech language pathologist, audiologist,
19 dietitian, or physician assistant qualified pursuant to §30-1-1 et seq. of this code.

20 (5) “Health care service” means:

21 (A) Physical and occupational therapy services;

22 (B) Obstetrical and gynecological services;

23 (C) Radiology and imaging services;

24 (D) Laboratory services;

25 (E) Infusion therapy;

26 (F) Inpatient or outpatient surgical procedures;

27 (G) Outpatient nonsurgical diagnostic tests or procedures; and

28 (H) Any services designated by the commissioner as shoppable by health care
29 consumers.

30 (6) “Hierarchical Condition Category Methodology” means a coding system designed by
31 the Centers for Medicare and Medicaid Services to estimate future health care costs for patients.

32 (7) “Insurer” means an accident and sickness insurer, fraternal benefit society, hospital
33 service corporation, medical service corporation, health care corporation, health maintenance
34 organization, preferred provider organization, provider sponsored health care corporation,
35 managed care entity, or any similar entity authorized to issue contracts under this title or to provide
36 health benefit policies. Insurer does not include plans that provide coverage through Medicaid
37 and CHIP.

§33-61-2. Publication of prices.

1 (a) As provided in Division BB, Title 1, Section 111, of the ‘No Surprises Act’ of 2020
2 insurer subject to §33-15-1 et seq., §33-16-1 et seq., §33-24-1 et seq., §33-25-1 et seq., §33-

3 25A-1 et seq., and PEIA shall make available on its publicly accessible website an interactive
4 mechanism whereby any member of the public may:

5 (1) For each health benefit policy offered, compare the payment amounts accepted by in-
6 network providers from such insurer for the provision of a particular health care service within the
7 previous year;

8 (2) For each health benefit policy offered, obtain an estimate of the average amount
9 accepted by in-network providers from such insurer for the provision of a particular health care
10 service within the previous year;

11 (3) For each health benefit policy offered, obtain an estimate of the out-of-pocket costs
12 that such covered person would owe his or her provider following the provision of a particular
13 health care service;

14 (4) Compare quality metrics applicable to in-network providers for major diagnostic
15 categories with adjustments by risk and severity based upon the Hierarchical Condition Category
16 Methodology or a nationally recognized health care quality reporting standard designated by the
17 commissioner. Metrics shall be based on reasonably universal and uniform data bases with
18 sufficient claim volume. If applicable to the provider, quality metrics shall include, but not be limited
19 to:

20 (A) Risk adjusted and absolute hospital readmission rates;

21 (B) Risk adjusted and absolute hospitalization rates;

22 (C) Admission volume;

23 (D) Utilization volume;

24 (E) Risk adjusted rates of adverse events; and

25 (F) Risk adjusted and absolute relative total cost of care.

26 (5) Access any all-payer health claims data base which may be maintained by the
27 department.

28 (b) An insurer subject to §33-15-1 et seq., §33-16-1 et seq., §33-24-1 et seq., §33-25-1 et
29 seq., §33-25A-1 et seq., and PEIA shall provide notification on its website that the actual amount
30 that a covered person will be responsible to pay following the receipt of a particular health care
31 service may vary due to unforeseen costs that arise during the provision of such service.

32 (c) Each estimate of out-of-pocket costs shall provide the following:

33 (1) The out-of-pocket costs a covered person may owe if he or she has exceeded his or
34 her deductible; and

35 (2) The out-of-pocket costs a covered person may owe if he or she has not exceeded his
36 or her deductible.

37 (d) An insurer subject to §33-15-1 et seq., §33-16-1 et seq., §33-24-1 et seq., §33-25-1 et
38 seq., §33-25A-1 et seq., and PEIA may contract with a third party to satisfy part or all of the
39 requirements of this section.

40 (e) Nothing in this section shall prohibit an insurer from charging a covered person cost
41 sharing beyond that included in the estimate provided, if such additional cost sharing resulted
42 from the unforeseen provision of additional health care services and the cost-sharing requirements
43 of such unforeseen health care services were disclosed in such covered person's policy or
44 certificate of insurance.

CHAPTER 47. REGULATION OF TRADE.

ARTICLE 29. HEALTH CARE SERVICES.

§47-29-1. Prices of health care services.

1 (a) When making an appointment to receive health care services, a patient shall receive
2 the cost estimate as provided in §33-61-1 et seq. of this code.

3 (b) A hospital may not charge a facility fee.

NOTE: The purpose of this bill is to provide more transparent healthcare costs to West Virginians, regulate out-of-state healthcare providers and non-network facility based providers, list disclosures of a healthcare facility and publication of a carrier's network, further define the responsibilities of a carrier inadvertent to out of state network services, provide binding arbitration for payment disputes, healthcare savings cost calculations, violations and legislative rules, provide for price transparency and a publication of prices, and provide the cost of healthcare at appointment.

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