WEST VIRGINIA CODE CHAPTER 33 ARTICLE 25A

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§33-25A-1. Short title and purpose.

(a) This article may be cited as the "Health Maintenance Organization Act of 1977."

(b) Faced with the continuation of mounting costs of health care coupled with its inaccessibility to large segments of the population, the Legislature has determined that there is a need to encourage alternative methods for the delivery of health care services, with a view toward achieving greater efficiency, availability, distribution and economy in providing these services.

In carrying out this intention, it is the policy of the state to eliminate legal barriers to the establishment of prepaid health care plans accountable to consumers for the health care services they provide; to provide for the financial and administrative soundness of these health care plans as it relates to their ability to provide such services, and to exempt prepaid health care plans from regulation as an insurer, the operation of insurance laws of the state and all other laws inconsistent with the purposes of this article.

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§33-25A-2. Definitions.

(1) "Basic health care services" means physician, hospital, out-of-area, podiatric, chiropractic, laboratory, X ray, emergency, treatment for serious mental illness as provided in section three-a, article sixteen of this chapter, and cost-effective preventive services including immunizations, well-child care, periodic health evaluations for adults, voluntary family planning services, infertility services, and children's eye and ear examinations conducted to determine the need for vision and hearing corrections, which services need not necessarily include all procedures or services offered by a service provider.

(2) "Capitation" means the fixed amount paid by a health maintenance organization to a health care provider under contract with the health maintenance organization in exchange for the rendering of health care services.

(3) "Commissioner" means the Commissioner of Insurance.

(4) "Consumer" means any person who is not a provider of care or an employee, officer, director or stockholder of any provider of care.

(5) "Copayment" means a specific dollar amount, or percentage, 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.

(6) "Employee" means a person in some official employment or position working for a salary or wage continuously for no less than one calendar quarter and who is in such a relation to another person that the latter may control the work of the former and direct the manner in which the work shall be done.

(7) "Employer" means any individual, corporation, partnership, other private association, or state or local government that employs the equivalent of at least two full-time employees during any four consecutive calendar quarters.

(8) "Enrollee", "subscriber" or "member" means an individual who has been voluntarily enrolled in a health maintenance organization, including individuals on whose behalf a contractual arrangement has been entered into with a health maintenance organization to receive health care services.

(9) "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee setting out the coverage and other rights to which the enrollee is entitled.

(10) "Health care services" means any services or goods included in the furnishing to any individual of medical, mental or dental care, or hospitalization or incident to the furnishing of the care or hospitalization, osteopathic services, chiropractic services, podiatric services, home health, health education or rehabilitation, as well as the furnishing to any person of any and all other services or goods for the purpose of preventing, alleviating, curing or

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healing human illness or injury.

(11) "Health maintenance organization" or "HMO" means a public or private organization which provides, or otherwise makes available to enrollees, health care services, including at a minimum basic health care services and which:

(A) Receives premiums for the provision of basic health care services to enrollees on a prepaid per capita or prepaid aggregate fixed sum basis, excluding copayments;

(B) Provides physicians' services primarily: (i) Directly through physicians who are either employees or partners of the organization; or (ii) through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice arrangement; or (iii) through some combination of paragraphs (i) and (ii) of this subdivision;

(C) Assures the availability, accessibility and quality, including effective utilization, of the health care services which it provides or makes available through clearly identifiable focal points of legal and administrative responsibility; and

(D) Offers services through an organized delivery system in which a primary care physician or primary care provider is designated for each subscriber upon enrollment. The primary care physician or primary care provider is responsible for coordinating the health care of the subscriber and is responsible for referring the subscriber to other providers when necessary: Provided, That when dental care is provided by the health maintenance organization the dentist selected by the subscriber from the list provided by the health maintenance organization shall coordinate the covered dental care of the subscriber, as approved by the primary care physician or the health maintenance organization.

(12) "Impaired" means a financial situation in which, based upon the financial information which would be required by this chapter for the preparation of the health maintenance organization's annual statement, the assets of the health maintenance organization are less than the sum of all of its liabilities and required reserves including any minimum capital and surplus required of the health maintenance organization by this chapter so as to maintain its authority to transact the kinds of business or insurance it is authorized to transact.

(13) "Individual practice arrangement" means any agreement or arrangement to provide medical services on behalf of a health maintenance organization among or between physicians or between a health maintenance organization and individual physicians or groups of physicians, where the physicians are not employees or partners of the health maintenance organization and are not members of or affiliated with a medical group.

(14) "Insolvent" or "insolvency" means a financial situation in which, based upon the financial information that would be required by this chapter for the preparation of the health maintenance organization's annual statement, the assets of the health maintenance organization are less than the sum of all of its liabilities and required reserves.

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(15) "Medical group" or "group practice" means a professional corporation, partnership, association or other organization composed solely of health professionals licensed to practice medicine or osteopathy and of other licensed health professionals, including podiatrists, dentists and optometrists, as are necessary for the provision of health services for which the group is responsible: (a) A majority of the members of which are licensed to practice medicine or osteopathy; (b) who as their principal professional activity engage in the coordinated practice of their profession; (c) who pool their income for practice as members of the group and distribute it among themselves according to a prearranged salary, drawing account or other plan; and (d) who share medical and other records and substantial portions of major equipment and professional, technical and administrative staff.

(16) "Point of service option" means a delivery system that permits an enrollee to receive health care services from a provider outside of the panel of providers with which the health maintenance organization has a contractual arrangement under the terms and conditions of the enrollee's contract with the health maintenance organization or the insurance carrier that provides the point of service option.

(17) "Premium" means a prepaid per capita or prepaid aggregate fixed sum unrelated to the actual or potential utilization of services of any particular person which is charged by the health maintenance organization for health services provided to an enrollee.

(18) "Primary care physician" means the general practitioner, family practitioner, obstetrician/gynecologist, pediatrician or specialist in general internal medicine who is chosen or designated for each subscriber who will be responsible for coordinating the health care of the subscriber, including necessary referrals to other providers.

(19) "Primary care provider" means a person who may be chosen or designated in lieu of a primary care physician for each subscriber, who will be responsible for coordinating the health care of the subscriber, including necessary referrals to other providers, and includes:

(A) An advanced nurse practitioner practicing in compliance with article seven, chapter thirty of this code and other applicable state and federal laws, who develops a mutually agreed upon association in writing with a primary care physician on the panel of and credentialed by the health maintenance organization; and

(B) A certified nurse-midwife, but only if chosen or designated in lieu of a subscriber's primary care physician or primary care provider during the subscriber's pregnancy and for a period extending through the end of the month in which the sixty-day period following termination of pregnancy ends.

(C) Nothing in this subsection may be construed to expand the scope of practice for advanced nurse practitioners as governed by article seven, chapter thirty of this code or any legislative rule, or for certified nurse-midwives, as defined in article fifteen, chapter thirty of this code.

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(20) "Provider" means any physician, hospital or other person or organization which is licensed or otherwise authorized in this state to furnish health care services.

(21) "Uncovered expenses" means the cost of health care services that are covered by a health maintenance organization, for which a subscriber would also be liable in the event of the insolvency of the organization.

(22) "Service area" means the county or counties approved by the commissioner within which the health maintenance organization may provide or arrange for health care services to be available to its subscribers.

(23) "Statutory surplus" means the minimum amount of unencumbered surplus which a corporation must maintain pursuant to the requirements of this article.

(24) "Surplus" means the amount by which a corporation's assets exceeds its liabilities and required reserves based upon the financial information which would be required by this chapter for the preparation of the corporation's annual statement except that assets pledged to secure debts not reflected on the books of the health maintenance organization shall not be included in surplus.

(25) "Surplus notes" means debt which has been subordinated to all claims of subscribers and general creditors of the organization.

(26) "Qualified independent actuary" means an actuary who is a member of the American academy of actuaries or the society of actuaries and has experience in establishing rates for health maintenance organizations and who has no financial or employment interest in the health maintenance organization.

(27) "Quality assurance" means an ongoing program designed to objectively and systematically monitor and evaluate the quality and appropriateness of the enrollee's care, pursue opportunities to improve the enrollee's care and to resolve identified problems at the prevailing professional standard of care.

(28) "Utilization management" means a system for the evaluation of the necessity, appropriateness and efficiency of the use of health care services, procedure and facilities.

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§33-25A-3. Application for certificate of authority.

(1) Notwithstanding any law of this state to the contrary, any person may apply to the commissioner for and obtain a certificate of authority to establish or operate a health maintenance organization in compliance with this article. No person shall sell health maintenance organization enrollee contracts, nor shall any health maintenance organization commence services, prior to receipt of a certificate of authority as a health maintenance organization. Any person may, however, establish the feasibility of a health maintenance organization prior to receipt of a certificate of authority through funding drives and by receiving loans and grants.

(2) Every health maintenance organization in operation as of the effective date of this article shall submit an application for a certificate of authority under this section within thirty days of the effective date of this article. Each applicant may continue to operate until the commissioner acts upon the application. In the event that an application is denied pursuant to section four of this article, the applicant shall be treated as a health maintenance organization whose certificate of authority has been revoked: Provided, That all health maintenance organizations in operation for at least five years are exempt from filing applications for a new certificate of authority.

(3) The commissioner may require any organization providing or arranging for health care services on a prepaid per capita or prepaid aggregate fixed sum basis to apply for a certificate of authority as a health maintenance organization. The commissioner shall promulgate rules to facilitate the enforcement of this subsection: Provided, That any provider who is assuming risk by virtue of a contract or other arrangement with a health maintenance organization or entity which has a certificate may not be required to file for a certificate: Provided, however, That the commissioner may require the exempted entities to file complete financial data for a determination as to their solvency. Any organization directed to apply for a certificate of authority is subject to the provisions of subsection (2) of this section.

(4) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner and shall set forth or be accompanied by any and all information required by the commissioner, including:

(a) The basic organizational document;

(b) The bylaws or rules;

(c) A list of names, addresses and official positions of each member of the governing body, which shall contain a full disclosure in the application of any financial interest by the officer or member of the governing body or any provider or any organization or corporation owned or controlled by that person and the health maintenance organization and the extent and nature of any contract or financial arrangements between that person and the health

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maintenance organization;

(d) A description of the health maintenance organization;

(e) A copy of each evidence of coverage form and of each enrollee contract form;

(f) Financial statements which include the assets, liabilities and sources of financial support of the applicant and any corporation or organization owned or controlled by the applicant;

(g)(i) A description of the proposed method of marketing the plan;

(ii) A schedule of proposed charges; and

(iii) A financial plan which includes a three-year projection of the expenses and income and other sources of future capital;

(h) A statement reasonably describing the service area or areas to be served and the type or types of enrollees to be served;

(i) A description of the complaint procedures to be utilized as required under section twelve of this article;

(j) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under section six of this article;

(k) A complete biographical statement on forms prescribed by the commissioner and an independent investigation report on all of the individuals referred to in subdivision (c) of this subsection and all officers, directors and persons holding five percent or more of the common stock of the organization;

(l) A comprehensive feasibility study, performed by a qualified independent actuary in conjunction with a certified public accountant which shall contain a certification by the qualified actuary and an opinion by the certified public accountant as to the feasibility of the proposed organization. The study shall be for the greater of three years or until the health maintenance organization has been projected to be profitable for twelve consecutive months. The study must show that the health maintenance organization would not, at the end of any month of the projection period, have less than the minimum capital and surplus as required by paragraph (ii), subdivision (c), subsection (2), section four of this article. The qualified independent actuary shall certify that: The rates are neither inadequate nor excessive nor unfairly discriminatory; the rates are appropriate for the classes of risks for which they have been computed; the rating methodology is appropriate: Provided, That the certification shall include an adequate description of the rating methodology showing that the methodology follows consistent and equitable actuarial principles; the health maintenance organization is actuarially sound: Provided, however, That the certification shall consider the rates, benefits and expenses of, and any other funds available for the payment of obligations of, the organization; the rates being charged or to be charged are actuarially adequate to the end of

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the period for which rates have been guaranteed; and incurred but not reported claims and claims reported but not fully paid have been adequately provided for;

(m) A description of the health maintenance organization's quality assurance program; and

(n) Such other information as the commissioner may require to be provided.

(5) A health maintenance organization shall, unless otherwise provided for by rules promulgated by the commissioner, file notice prior to any modification of the operations or documents filed pursuant to this section or as the commissioner may require by rule. If the commissioner does not disapprove of the filing within ninety days of filing, it shall be considered approved and may be implemented by the health maintenance organization.

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§33-25A-3a. Conditions precedent to issuance or maintenance of a certificate of authority; renewal of certificate of authority; effect of bankruptcy proceedings.

(a) As a condition precedent to the issuance or maintenance of a certificate of authority, a health maintenance organization shall file or have on file with the Commissioner:

(1) An acknowledgment that a delinquency proceeding pursuant to article ten of this chapter, or supervision by the Commissioner pursuant to article thirty-four of this chapter, constitute the exclusive methods for the liquidation, rehabilitation, reorganization or conservation of a health maintenance organization;

(2) A waiver of any right to file or be subject to a bankruptcy proceeding;

(3) Within thirty days of any change in the membership of the governing body of the organization or in the officers or persons holding five percent or more of the common stock of the organization, or as otherwise required by the Commissioner:

(A) An amended list of the names, addresses and official positions of each member of the governing body and a full disclosure of any financial interest by a member of the governing body or any provider or any organization or corporation owned or controlled by that person and the health maintenance organization and the extent and nature of any contract or financial arrangements between that person and the health maintenance organization; and

(B) A complete biographical statement on forms prescribed by the Commissioner and an independent investigation report on each person for whom a biographical statement and independent investigation report have not previously been submitted; and

(4) For health maintenance organizations that have been operating in this state for at least three years, a copy of the current quality assurance report submitted to the health maintenance organization by a nationally recognized accreditation and review organization approved by the Commissioner, or in the case of the issuance of an initial certificate of authority to a health maintenance organization, a determination by the Commissioner as to the feasibility of the health maintenance organization's proposed quality assurance program: Provided, That if a health maintenance organization files proof found in the Commissioner's discretion to be sufficient to demonstrate that the health maintenance organization has timely applied for and reasonably pursued a review of its quality assurance program, but a quality report has not been issued by the accreditation and review organization, the health maintenance organization shall be considered to have complied with this subdivision.

(b) All certificates of authority issued to health maintenance organizations expire at midnight on the thirty-first day of May of each year. The Commissioner shall renew annually the certificates of authority of all health maintenance organizations that continue to meet all requirements of this section and subsection (2), section four of this article: Provided, That a health maintenance organization shall not qualify for renewal of its certificate of authority if the organization has no subscribers in this state within twelve months after issuance of the

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certificate of authority: Provided, however, That an organization not qualifying for renewal may apply for a new certificate of authority under section three of this article.

(c) The commencement of a bankruptcy proceeding either by or against a health maintenance organization shall, by operation of law;

Terminate the health maintenance organization's certificate of authority; and

Vest in the Commissioner for the use and benefit of the subscribers of the health maintenance organization the title to any deposits of the health maintenance organization held by the Commissioner: Provided, That if the bankruptcy proceeding is initiated by a party other than the health maintenance organization, the operation of this subsection shall be stayed for a period of sixty days following the date of commencement of the proceeding.

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§33-25A-4. Issuance of certificate of authority.

(1) Upon receipt of an application for a certificate of authority, the commissioner shall determine whether the application for a certificate of authority, with respect to health care services to be furnished, has demonstrated:

(a) The willingness and potential ability of the organization to assure that basic health services will be provided in a manner to enhance and assure both the availability and accessibility of adequate personnel and facilities;

(b) Arrangements for an ongoing evaluation of the quality of health care provided by the organization and utilization review which meet those standards required by the commissioner by rule; and

(c) That the organization has a procedure to develop, compile, evaluate and report statistics relating to the cost of its operations, the pattern of utilization of its services, the quality, availability and accessibility of its services and any other matters reasonably required by rule.

(2) The commissioner shall issue or deny a certificate of authority to any person filing an application within one hundred twenty days after receipt of the application. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed, if the commissioner is satisfied that the following conditions are met:

(a) The health maintenance organization's proposed plan of operation meets the requirements of subsection (1) of this section;(b) The health maintenance organization will effectively provide or arrange for the provision of at least basic health care services on a prepaid basis except for copayments: Provided, That nothing in this section shall be construed to relieve a health maintenance organization from the obligations to provide health care services because of the nonpayment of copayments unless the enrollee fails to make payment in at least three instances over any twelve-month period: Provided, however, That nothing in this section shall permit a health maintenance organization to charge copayments to Medicare beneficiaries or Medicaid recipients in excess of the copayments permitted under those programs, nor shall a health maintenance organization be required to provide services to the Medicare beneficiaries or Medicaid recipients in excess of the benefits compensated under those programs;

(c) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

(i) The financial soundness of the health maintenance organization's arrangements for health care services and the proposed schedule of charges used in connection with the health care services;

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(ii) That the health maintenance organization has and maintains the following:

(A) If a for-profit stock corporation, at least $1 million of fully paid-in capital stock; or

(B) If a nonprofit corporation, at least $1 million of statutory surplus funds; and

(C) Both for-profit and nonprofit health maintenance organization, additional surplus funds of at least $1 million;

(iii) Any arrangements that will guarantee for the continuation of benefits and payments to providers for services rendered both prior to and after insolvency for the duration of the contract period for which payment has been made, except that benefits to members who are confined on the date of insolvency in an inpatient facility shall be continued until their discharge; and

(iv) Any agreement with providers for the provision of health care services;

(d) Reasonable provisions have been made for emergency and out-of-area health care services;

(e) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to section six of this article;

(f) The health maintenance organization has demonstrated that it will assume full financial risk on a prospective basis for the provision of health care services, including hospital care: Provided, That the requirement of this subdivision shall not prohibit a health maintenance organization from obtaining reinsurance acceptable to the commissioner from an accredited reinsurer or making other arrangements acceptable to the commissioner:

(i) For the cost of providing to any enrollee health care services, the aggregate value of which exceeds $4,000 in any year;

(ii) For the cost of providing health care services to its members on a nonelective emergency basis, or while they are outside the area served by the organization; or

(iii) For not more than ninety-five percent of the amount by which the health maintenance organization's costs for any of its fiscal years exceed one hundred five percent of its income for those fiscal years;

(g) The ownership, control and management of the organization is competent and trustworthy and possesses managerial experience that would make the proposed health maintenance organization operation beneficial to the subscribers. The commissioner may, at his or her discretion, refuse to grant or continue authority to transact the business of a health maintenance organization in this state at any time during which the commissioner has probable cause to believe that the ownership, control or management of the organization includes any person whose business operations are or have been marked by business

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practices or conduct that is to the detriment of the public, stockholders, investors or creditors;

(h) The health maintenance organization has deposited and maintained in trust with the State Treasurer, for the protection of its subscribers or its subscribers and creditors, cash or government securities eligible for the investment of capital funds of domestic insurers as described in paragraph (A) or (B), subdivision (1), subsection (a), section eleven, article eight of this chapter or paragraph (A), (B) or (C), subdivision (3) of said subsection, in the amount of $100,000; and

(i) The health maintenance organization has a quality assurance program which has been reviewed by the commissioner or by a nationally recognized accreditation and review organization approved by the commissioner; meets at least those standards set forth in section seventeen-a of this article; and is determined satisfactory by the commissioner. If the commissioner determines that the quality assurance program of a health maintenance organization is deficient in any significant area, the commissioner, in addition to other remedies provided in this chapter, may establish a corrective action plan that the health maintenance organization must follow as a condition to the issuance of a certificate of authority: Provided, That in those instances where a health maintenance organization has timely applied for and reasonably pursued a review of its quality assurance program, but the review has not been completed, the health maintenance organization shall submit proof to the commissioner of its application for that review.

(3) A certificate of authority shall be denied only after compliance with the requirements of section twenty-one of this article.

(4) No person who has not been issued a certificate of authority shall use the words "health maintenance organization" or the initials "HMO" in its name, contracts, logo or literature: Provided, That persons who are operating under a contract with, operating in association with, enrolling enrollees for, or otherwise authorized by a health maintenance organization licensed under this article to act on its behalf may use the terms "health maintenance organization", or "HMO" for the limited purpose of denoting or explaining their association or relationship with the authorized health maintenance organization. No health maintenance organization which has a minority of board members who are consumers shall use the words "consumer controlled" in its name or in any way represent to the public that it is controlled by consumers.

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§33-25A-5. Powers of health maintenance organizations.

(a) Upon obtaining a certificate of authority as required under this article, a health maintenance organization may enter into health maintenance contracts in this state and engage in any activities, consistent with the purposes and provisions of this article, which are necessary to the performance of its obligations under such contracts, subject to the limitations provided in this article. A health maintenance organization may offer to its enrollees in conjunction with the benefits provided to them through their contractual arrangement for health services with the health maintenance organization a point of service option to be provided either by the health maintenance organization directly or by an insurance carrier licensed in this state with which the health maintenance organization has a contractual arrangement. Benefits for health care services within the health maintenance organization's contracted provider panel shall comply with all other provisions of this article.

(b) The commissioner shall propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code limiting or regulating the powers of health maintenance organizations which the commissioner finds to be in the public interest. The commissioner may promulgate emergency rules pursuant to the provisions of section fifteen, article three, chapter twenty-nine-a of this code to implement standards and requirements for a point of service option.

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§33-25A-6. Governing body.

(1) The governing body of any health maintenance organization may include enrollees, providers, or other individuals.

(2) Such governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms as may be prescribed by the commissioner.

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§33-25A-7. Fiduciary responsibilities of officers; fidelity bond; approval of contracts by commissioner.

(a) Any director, officer or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of the organization is responsible for the funds in a fiduciary relationship to the enrollees.

(b) A health maintenance organization shall maintain a blanket fidelity bond covering all directors, officers, managers and employees of the organization who receive, collect, disburse or invest funds in connection with the activities of the organization, issued by an insurer licensed in this state or, if the fidelity bond required by this subsection is not available from an insurer licensed in this state, a fidelity bond procured by an excess line broker licensed in this state, in an amount at least equal to the minimum amount of fidelity insurance as provided in the national association of Insurance Commissioners handbook, as amended, or as determined under a rule promulgated by the commissioner.

(c) Any contracts made with providers of health care services enabling a health maintenance organization to provide health care services authorized under this article shall be filed with the commissioner. The commissioner has the power to require immediate cancellation of the contracts or the immediate renegotiation of the contract by the parties whenever he or she determines that they provide for excessive payments, or that they fail to include reasonable incentives for cost control, or that they otherwise substantially and unreasonably contribute to escalation of the costs of providing health care services to enrollees.

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§33-25A-7a. Provider contracts.

(1) Whenever a contract exists between a health maintenance organization and a provider and the organization fails to meet its obligations to pay fees for services already rendered to a subscriber, the health maintenance organization is liable for the fee or fees rather than the subscriber; and the contract shall state that liability.

(2) No subscriber of a health maintenance organization is liable to any provider of health care services for any services covered by the health maintenance organization if at any time during the provision of the services, the provider, or its agents, are aware the subscriber is a health maintenance organization enrollee.

(3) If at any time during the provision of the services, a provider, or its agents, are aware that the subscriber is a health maintenance organization enrollee, that provider of services or any representative of the provider may not collect or attempt to collect from a health maintenance organization subscriber any money for services covered by a health maintenance organization and no provider or representative of the provider may maintain any action at law against a subscriber of a health maintenance organization to collect money owed to the provider by a health maintenance organization.

(4) Every contract between a health maintenance organization and a provider of health care services shall be in writing and shall contain a provision that the subscriber is not liable to the provider for any services covered by the subscriber's contract with the health maintenance organization.

(5) The provisions of this section shall not be construed to apply to the amount of any deductible or copayment which is not covered by the contract of the health maintenance organization.

(6) When a subscriber receives covered emergency health care services from a noncontracting provider, the health maintenance organization shall be responsible for payment of the providers normal charges for those health care services, exclusive of any applicable deductibles or copayments.

(7) For all provider contracts executed on or after April 15, one thousand nine hundred ninety-five, and within one hundred eighty days of that date for contracts in existence on that date:

(a) The contracts must provide that the provider shall provide sixty days advance written notice to the health maintenance organization and the commissioner before canceling the contract with the health maintenance organization for any reason; and

(b) The contract must also provide that nonpayment for goods or services rendered by the provider to the health maintenance organization is not a valid reason for avoiding the sixty day advance notice of cancellation.

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(8) Upon receipt by the health maintenance organization of a sixty day cancellation notice, the health maintenance organization may, if requested by the provider, terminate the contract in less than sixty days if the health maintenance organization is not financially impaired or insolvent.

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§33-25A-7b. Loss ratio.

If a health maintenance organization considers a loss ratio at the time of renewal of a policy, plan, or contract, the health maintenance organization shall, upon request of a subscriber, provide the loss ratio and the components of the loss ratio calculation to the subscriber no more than 90 days but no less than 60 days before the renewal date of the policy, plan, or contract. For purposes of this section, "loss ratio" means the total losses paid out in medical claims divided by the total earned premiums: *Provided, however*, That medical claims do not include dental only or vision only coverage. For purposes of this section, "subscriber" does not include a subscriber or beneficiary of any policy, plan, or contract approved by the Bureau of Medical Services and entered into by a health maintenance organization with Medicaid or the Children's Health Insurance Program.

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§33-25A-8. Evidence of coverage; charges for health care services; review of enrollee records; cancellation of contract by enrollee.

(1) (a) Every enrollee is entitled to evidence of coverage in accordance with this section. The health maintenance organization or its designated representative shall issue the evidence of coverage.

(b) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the commissioner.

(c) An evidence of coverage shall contain a clear, concise and complete statement of:

(i) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) Any exclusions or limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any copayments;

(iii) Where and in what manner information is available as to how services, including emergency and out-of-area services, may be obtained;

(iv) The total amount of payment and copayment, if any, for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates;

(v) A description of the health maintenance organization's method for resolving enrollee grievances; and

(vi) The following exact statement in bold print: "Each subscriber or enrollee, by acceptance of the benefits described in this evidence of coverage, shall be deemed to have consented to the examination of his or her medical records for purposes of utilization review, quality assurance and peer review by the health maintenance organization or its designee."

(d) Any subsequent approved change in an evidence of coverage shall be issued to each enrollee.

(e) A copy of the form of the evidence of coverage to be used in this state, and any amendment thereto, is subject to the filing and approval requirements of subdivision (b), subsection (1) of this section, unless the commissioner promulgates a rule dispensing with this requirement or unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or, hospital or medical service corporations, in which event the filing and approval provisions of those laws apply. To the extent, however, that those provisions do not apply the requirements in subdivision (c), subsection (1) of this section, are applicable.

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(2) Premiums may be established in accordance with actuarial principles: Provided, That premiums shall not be excessive, inadequate or unfairly discriminatory. A certification by a qualified independent actuary shall accompany a rate filing and shall certify that: The rates are neither inadequate nor excessive nor unfairly discriminatory; that the rates are appropriate for the classes of risks for which they have been computed; provide an adequate description of the rating methodology showing that the methodology follows consistent and equitable actuarial principles; and the rates being charged are actuarially adequate to the end of the period for which rates have been guaranteed. In determining whether the charges are reasonable, the commissioner shall consider whether the health maintenance organization has: (a) Made a vigorous, good faith effort to control rates paid to health care providers; (b) established a premium schedule, including copayments, if any, which encourages enrollees to seek out preventive health care services; (c) made a good faith effort to secure arrangements whereby basic services can be obtained by subscribers from local providers to the extent that the providers offer the services; and (d) made a good faith effort to support community health assessments and efforts directed at community health needs.

(3) Rates are inadequate if the premiums derived from the rating structure, plus investment income, copayments, and revenues from coordination of benefits and subrogation, fees-for-service and reinsurance recoveries are not set at a level at least equal to the anticipated cost of medical and hospital benefits during the period for which the rates are to be effective, and the other expenses which would be incurred if other expenses were at the level for the current or nearest future period during which the health maintenance organization is projected to make a profit. For this analysis, investment income shall not exceed three percent of total projected revenues.

(4) The commissioner shall within a reasonable period approve any form if the requirements of subsection (1) of this section are met and any schedule of charges if the requirements of subsection (2) of this section are met. It is unlawful to issue the form or to use the schedule of charges until approved. If the commissioner disapproves of the filing, he or she shall notify the filer promptly. In the notice, the commissioner shall specify the reasons for his or her disapproval and the findings of fact and conclusions which support his or her reasons. A hearing will be granted by the commissioner within fifteen days after a request in writing, by the person filing, has been received by the commission. If the commissioner does not disapprove any form or schedule of charges within sixty days of the filing of the forms or charges, they shall be considered approved.

(5) The commissioner may require the submission of whatever relevant information in addition to the schedule of charges which he or she considers necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(6) An individual enrollee may cancel a contract with a health maintenance organization at any time for any reason: Provided, That a health maintenance organization may require that the enrollee give thirty days advance notice: Provided, however, That an individual enrollee whose premium rate was determined pursuant to a group contract may cancel a contract

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with a health maintenance organization pursuant to the terms of that contract.

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§33-25A-8a. Third party reimbursement for mammography, pap smear or human papilloma virus testing.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, whenever reimbursement or indemnity for laboratory or X-ray services are covered, reimbursement or indemnification shall not be denied for any of the following when performed for cancer screening or diagnostic purposes, at the direction of a person licensed to practice medicine and surgery by the Board of Medicine:

(1) Mammograms when medically appropriate and consistent with the current guidelines from the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists.

(2) A pap smear, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists, for women age eighteen or over; or

(3) A test for the human papilloma virus (HPV)for women age eighteen or over, when medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists for women age eighteen and over.

(b) A policy, provision, contract, plan or agreement may apply to mammograms, pap smears or human papilloma virus (HPV) test the same deductibles, coinsurance and other limitations as apply to other covered services.

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§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, provide as benefits to all subscribers and members coverage for rehabilitation services as hereinafter set forth, unless rejected by the insured.

(b) 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.

(c) 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.

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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.

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

(e) 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.

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§33-25A-8c. Third party payment for child immunization services.

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, 1994, provide as benefits to all subscribers and members coverage for child immunization services as described in section five, article three, chapter sixteen of this code. This coverage will cover all costs associated with immunization, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration. These services shall be exempt from any deductible, per-visit charge and/or copayment provisions which may be in force in these policies, provisions, plans, agreements or contracts. This section does not require that other health care services provided at the time of immunization be exempt from any deductible and/or copayment provisions.

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§33-25A-8d. Coverage of emergency 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 provide as benefits to all subscribers and members coverage for emergency services. A policy, provision, contract, plan, or agreement may apply to emergency services the same deductibles, coinsurance, and other limitations as apply to other covered services: *Provided*, That preauthorization or precertification shall not be required.

(b) From July 1, 1998, the following provisions apply:

(1) Every insurer shall provide coverage for emergency medical services, including prehospital services, to the extent necessary to screen and to stabilize an emergency medical condition. The insurer shall not require prior authorization of the screening services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Prior authorization of coverage shall not be required for stabilization if an emergency medical condition exists. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(2) The coverage for prehospital screening and stabilization of an emergency medical condition shall include ambulance services provided under the provisions of §16-4C-1 *et seq*. of this code, excluding air ambulance services as defined in §16-4C-3(a) of this code. The insurer shall pay claims for prehospital screening and stabilization of emergency condition by ambulance service if the insured is transported to an emergency room of a facility provider or if the patient declines to be transported against medical advice. The coverage under this section is subject to deductibles or copayment requirements of the policy, contract, or plan.

(3) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health condition made by the referring provider, the provider of the emergency services, or the covered person.

(4) Coverage of emergency services shall be subject to coinsurance, copayments, and deductibles applicable under the health benefit plan.

(5) The emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite post evaluation or post stabilization services in order to avoid material deterioration of the covered person's condition.

(6) As used in this section:

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(A) "Emergency medical services" means those services required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care;

(B) "Prudent layperson" means a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether an emergency medical condition exists for which emergency treatment should be sought;

(C) "Emergency medical condition for the prudent layperson" means one that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the person could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health, or, with respect to a pregnant woman, the health of the unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part;

(D) "Stabilize" means with respect to an emergency medical condition, to provide medical treatment of the condition necessary to assure, with reasonable medical probability, that no medical deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility: *Provided*, That this provision may not be construed to prohibit, limit, or otherwise delay the transportation required for a higher level of care than that possible at the treating facility;

(E) "Medical screening examination" means an appropriate examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists; and

(F) "Emergency medical condition" means a condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or with respect to a pregnant woman, the health of the unborn child, serious impairment to bodily functions or serious dysfunction of any bodily part or organ.

(7) Each insurer shall provide the enrolled member with a description of procedures to be followed by the member for emergency services, including the following:

(A) The appropriate use of emergency facilities;

(B) The appropriate use of any prehospital services provided by the health maintenance organization;

(C) Any potential responsibility of the member for payment for nonemergency services rendered in an emergency facility;

(D) Any cost-sharing provisions for emergency services; and

(E) An explanation of the prudent layperson standard for emergency medical condition.

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§33-25A-8e. Third party reimbursement for colorectal cancer examination and laboratory testing.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, reimbursement or indemnification for colorectal cancer examinations and laboratory testing may not be denied for any nonsymptomatic person fifty years of age or older, or a symptomatic person under fifty years of age, when reimbursement or indemnity for laboratory or X-ray services are covered under the policy and are performed for colorectal cancer screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery by the Board of Medicine. The tests are as follows: An annual fecal occult blood test, a flexible sigmoidoscopy repeated every five years, a colonoscopy repeated every ten years and a double contrast barium enema repeated every five years.

(b) A symptomatic person is defined as: (i) An individual who experiences a change in bowel habits, rectal bleeding or stomach cramps that are persistent; or (ii) an individual who poses a higher than average risk for colorectal cancer because he or she has had colorectal cancer or polyps, inflammatory bowel disease, or an immediate family history of such conditions.

(c) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered person may apply to colorectal cancer examinations and laboratory testing.

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§33-25A-8f. Required coverage for reconstruction surgery following mastectomies.

(a) Any policy of insurance described in this article which provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

(1) All stages of reconstruction of the breast on which the mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Prostheses and physical complications of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient. Coverage shall be provided for a minimum stay in the hospital of not less than forty-eight hours for a patient following a radical or modified mastectomy and not less than twenty-four hours of inpatient care following a total mastectomy or partial mastectomy with lymph node dissection for the treatment of breast cancer. Nothing in this section shall be construed as requiring inpatient coverage where inpatient coverage is not medically necessary or where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the health benefit plan policy or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

(b) A health benefit plan policy, and a health insurer providing health insurance coverage in connection with a health benefit plan policy, shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the issuer of the health benefit plan policy.

(c) A health benefit plan policy and a health insurer offering health insurance coverage in connection with a health benefit plan policy, may not:

(1) Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

(d) Nothing in this section shall be construed to prevent a health benefit plan policy or a health insurer offering health insurance coverage from negotiating the level and type of

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reimbursement with a provider for care provided in accordance with this section.

(e) The provisions of this section shall be included under any policy, contract or plan delivered after July 1, 2002.

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§33-25A-8g. Required use of mail-order pharmacy prohibited.

(a) A health maintenance organization issuing coverage in this state pursuant to the provisions of this article may not require any person covered under a contract which provides coverage for prescription drugs to obtain the prescription drugs from a mail-order pharmacy in order to obtain benefits for the drugs.

(b) A health maintenance organization may not violate the provisions of subsection (a) of this section through the use of an agent or contractor or through the action of an administrator of prescription drug benefits.

(c) The Insurance Commissioner may propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code to implement and enforce the provisions of this section.

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§33-25A-8h. Third-party reimbursement for kidney disease screening.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, reimbursement or indemnification for annual kidney disease screening and laboratory testing as recommended by the National Kidney Foundation may not be denied for any person when reimbursement or indemnity for laboratory or X-ray services are covered under the policy and are performed for kidney disease screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery by the Board of Medicine. The tests are as follows: Any combination of blood pressure testing, urine albumin or urine protein testing and serum creatinine testing.

(b) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered person may apply to kidney disease screening and laboratory testing.

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§33-25A-8i. Third-party reimbursement for dental anesthesia 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, 2009, provide as benefits to all subscribers and members coverage for dental anesthesia services as hereinafter set forth.

(b) For purposes of this section, "dental anesthesia services" means general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care provided to a subscriber or member if the subscriber or member is:

(1) Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the subscriber or member and for whom a superior result can be expected from dental care provided under general anesthesia; or

(2) A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth, or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

(c) Prior authorization. -- An entity subject to this section may require prior authorization for general anesthesia and associated outpatient hospital, ambulatory facility or similar charges for dental care in the same manner that prior authorization is required for these benefits in connection with other covered medical care.

(d) An entity subject to this section may restrict coverage for general anesthesia and associated outpatient hospital or ambulatory facility charges unless the dental care is provided by:

(1) A fully accredited specialist in pediatric dentistry;

(2) A fully accredited specialist in oral and maxillofacial surgery; and

(3) A dentist to whom hospital privileges have been granted.

(e) Dental care coverage not required. -- The provisions of this section may not be construed to require coverage for the dental care for which the general anesthesia is provided.

(f) Temporal mandibular joint disorders. -- The provisions of this section do not apply to dental care rendered for temporal mandibular joint disorders.

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(g) A policy, provision, contract, plan or agreement may apply to dental anesthesia services the same deductibles, coinsurance and other limitations as apply to other covered services.

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§33-25A-8j. Coverage for diagnosis and treatment of autism spectrum disorders.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article for policies issued or renewed on or after January 1, 2012, which delivers, renews or issues a policy of group accident and sickness insurance in this state under the provisions of this article shall include coverage for diagnosis, evaluation and treatment of autism spectrum disorder in individuals ages eighteen months to eighteen years. To be eligible for coverage and benefits under this section, the individual must be diagnosed with autism spectrum disorder at age eight or younger. The policy shall provide coverage for treatments that are medically necessary and ordered or prescribed by a licensed physician or licensed psychologist and in accordance with a treatment plan developed from a comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism spectrum disorder.

(b) Coverage shall include, but not be limited to, applied behavior analysis. Applied behavior analysis shall be provided or supervised by a certified behavior analyst. The annual maximum benefit for applied behavior analysis required by this subsection shall be in amount not to exceed $30,000 per individual, for three consecutive years from the date treatment commences. At the conclusion of the third year, coverage for applied behavior analysis required by this subsection shall be in an amount not to exceed $2,000 per month, until the individual reaches eighteen years of age, as long as the treatment is medically necessary and in accordance with a treatment plan developed by a certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual. This section shall not be construed as limiting, replacing or affecting any obligation to provide services to an individual under the Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq., as amended from time to time or other publicly funded programs. Nothing in this section shall be construed as requiring reimbursement for services provided by public school personnel.

(c) The certified behavior analyst shall file progress reports with the agency semiannually. In order for treatment to continue, the agency must receive objective evidence or a clinically supportable statement of expectation that:

(1) The individual's condition is improving in response to treatment; and

(2) A maximum improvement is yet to be attained; and

(3) There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

(d) For purposes of this section, the term:

(1) "Applied Behavior Analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and

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behavior.

(2) "Autism spectrum disorder" means any pervasive developmental disorder, including autistic disorder, Asperger's Syndrome, Rett syndrome, childhood disintegrative disorder, or Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(3) "Certified behavior analyst" means an individual who is certified by the Behavior Analyst Certification Board or certified by a similar nationally recognized organization.

(4) "Objective evidence" means standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and after treatment is recommended to quantify progress and support justifications for continued treatment. The tools are not required, but their use will enhance the justification for continued treatment.

(e) The provisions of this section do not apply to small employers. For purposes of this section a small employer means any person, firm, corporation, partnership or association actively engaged in business in the State of West Virginia who, during the preceding calendar year, employed an average of no more than twenty-five eligible employees.

(f) To the extent that the application of this section for autism spectrum disorder causes an increase of at least one percent of actual total costs of coverage for the plan year the health maintenance organization may apply additional cost containment measures.

(g) To the extent that the provisions of this section require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of a health benefit plan when the plan is offered by a health maintenance organization in this state.

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§33-25A-8k. Maternity coverage.

Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, a health insurance policy subject to this article, issued or renewed on or after January 1, 2014, which provides health insurance coverage for maternity services, shall provide coverage for maternity services for all persons participating in, or receiving coverage under the policy. To the extent that the provisions of this section require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits are not required of a health benefit plan when the plan is offered by a health care insurer in this state. Coverage required under this section may not be subject to exclusions or limitations which are not applied to other maternity coverage under the policy.

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§33-25A-8l. Deductibles, copayments and coinsurance for anti-cancer medications.

(a) Notwithstanding any provision of any policy, contract, plan or agreement to which this article applies, any policy, contract, plan or agreement issued by a health maintenance organization pursuant to this article that covers anti-cancer medications that are injected or intravenously administered by a health care provider and patient administered anti-cancer medications, including, but not limited to, those medications orally administered or self-injected, may not require a less favorable basis for a copayment, deductible or coinsurance amount for patient administered anti-cancer medications than it requires for injected or intravenously administered anti-cancer medications, regardless of the formulation or benefit category determination by the policy or plan.

(b) A policy, contract, plan or agreement or a health maintenance organization may not comply with subsection (a) of this section by:

(1) Increasing the copayment, deductible or coinsurance amount required for injected or intravenously administered anti-cancer medications that are covered under the policy, contract, or plan or agreement; or

(2) Reclassifying benefits with respect to anti-cancer medications.

(c) As used in this section, "anti-cancer medication" means a FDA approved medication prescribed by a treating physician who determines that the medication is medically necessary to kill or slow the growth of cancerous cells in a manner consistent with nationally accepted standards of practice.

(d) This section is effective for policy, contract, plan or agreement beginning on or after January 1, 2016. This section applies to all policies, contracts, plans or agreements subject to this article that are delivered, executed, issued, amended, adjusted or renewed in this state, on and after the effective date of this section.

(e) Notwithstanding any other provision in this section to the contrary, in the event that a health maintenance organization subject to this article can demonstrate actuarially to the Insurance Commissioner that its total anticipated costs for any health maintenance contract to comply with this section will exceed or have exceeded two percent of the total costs for the policy, contract, plan or agreement in any experience period, then the health maintenance organization may apply whatever cost containment measures may be necessary to maintain costs below two percent of the total costs for the policy, contract, plan or agreement: Provided, That such cost containment measures implemented are applicable only for the plan year or experience period following approval of the request to implement cost containment measures.

(f) For any enrollee that is enrolled in a catastrophic plan as defined in Section 1302(e) of the Affordable Care Act or in a plan that, but for this requirement, would be a High Deductible Health Plan as defined in section 223(c)(2)(A) of the Internal Revenue Code of

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1986, and that, in connection with every enrollment, opens and maintains for each enrollee a Health Savings Account as that term is defined in section 223(d) of the Internal Revenue Code of 1986, the cost-sharing limit outlined in subsection (a) of this section shall be applicable only after the minimum annual deductible specified in section 223(c)(2)(A) of the Internal Revenue Code of 1986 is reached. In all other cases, this limit shall be applicable at any point in the benefit design, including before and after any applicable deductible is reached.

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§33-25A-8m. Eye drop prescription refills.

A contract, plan or agreement issued by an insurer pursuant to this article for prescription topical eye medication may not deny coverage for the refilling of a prescription for topical eye medication when:

(1) The medication is to treat a chronic condition of the eye;

(2) The refill is requested by the insured prior to the last day of the prescribed dosage period and after at least 70% of the predicted days of use; and

(3) A person licensed under chapter thirty and authorized to prescribe topical eye medication indicates on the original prescription that refills are permitted and that the early refills requested by the insured do not exceed the total number of refills prescribed.

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§33-25A-8n. Deductibles, copayments and coinsurance for abuse-deterrent opioid analgesic drugs.

(a) As used in this section:

(1) "Abuse-deterrent opioid analgesic drug product" means a brand name or generic opioid analgesic drug product approved by the United States Food and Drug Administration with abuse-deterrent labeling that indicates its abuse-deterrent properties are expected to deter or reduce its abuse;

(2) "Cost-sharing" means any coverage limit, copayment, coinsurance, deductible or other out-of-pocket expense requirements;

(3) "Opioid analgesic drug product" means a drug product that contains an opioid agonist and is indicated by the United States Food and Drug Administration for the treatment of pain, regardless of whether the drug product:

(A) Is in immediate release or extended release form; or

(B) Contains other drug substances.

(b) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, on or after January 1, 2017:

(1) Coverage shall be provided for at least one abuse-deterrent opioid analgesic drug product for each active opioid analgesic ingredient;

(2) Cost-sharing for brand name abuse-deterrent opioid analgesic drug products shall not exceed the lowest tier for brand name prescription drugs on the entity's formulary for prescription drug coverage;

(3) Cost-sharing for generic abuse-deterrent opioid analgesic drug products covered pursuant to this section shall not exceed the lowest cost-sharing level applied to generic prescription drugs covered under the applicable health plan or policy; and

(4) An entity subject to this section may not require an insured or enrollee to first use an opioid analgesic drug product without abuse-deterrent labeling before providing coverage for an abuse-deterrent opioid analgesic drug product covered on the entity's formulary for prescription drug coverage.

(c) Notwithstanding subdivision (3), subsection (b) of this section, an entity subject to this section may undertake utilization review, including preauthorization, for an abuse-deterrent opioid analgesic drug product covered by the entity, if the same utilization review requirements are applied to nonabuse-deterrent opioid analgesic drug products and with the same type of drug release, immediate or extended.

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(d) For purposes of subsection (b) of this section, the lowest tier and the lowest cost-sharing level shall not mean the cost-sharing tier applicable to preventive care services which are required to be provided at no cost-sharing under the Patient Protection and Affordable Care Act.

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§33-25A-8o. Step therapy.

(a) As used in this article:

(1) “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(2) “Health plan issuer” or “issuer” means an entity required to be licensed under this chapter that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including accident and sickness insurers, nonprofit hospital service corporations, medical service corporations and dental service organizations, prepaid limited health service organizations, health maintenance organizations, preferred provider organizations, provider sponsored network, and any pharmacy benefit manager that administers a fully-funded or self-funded plan.

(3) “Step therapy protocol” means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition, and medically appropriate for a particular patient, are covered by a health plan issuer or health benefit plan.

(4) “Step therapy override determination” means a determination as to whether a step therapy protocol should apply in a particular situation, or whether the step therapy protocol should be overridden in favor of immediate coverage of the health care provider’s selected prescription drug. This determination is based on a review of the patient’s or prescriber’s request for an override, along with supporting rationale and documentation.

(5) “Utilization review organization” means an entity that conducts utilization review, other than a health plan issuer performing utilization review for its own health benefit plan.

(b) A health benefit plan that includes prescription drug benefits, and which utilizes step therapy protocols, and which is issued for delivery, delivered, renewed, or otherwise contracted in this state on or after January 1, 2018, shall comply with the provisions of this article.

(c) Step therapy protocol exceptions include:

(1) When coverage of a prescription drug for the treatment of any medical condition is restricted for use by health plan issuer or utilization review organization through the use of a step therapy protocol, the patient and prescribing practitioner shall have access to a clear and convenient process to request a step therapy exception determination. The process shall be made easily accessible on the health plan issuer’s or utilization review organization’s website. The health plan issuer or utilization review organization must provide a prescription drug for treatment of the medical condition at least until the step therapy exception

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determination is made.

(2) A step therapy override determination request shall be expeditiously granted if:

(A) The required prescription drug is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient.

(B) The required prescription drug is expected to be ineffective based on the known relevant physical or mental characteristics of the patient and the known characteristics of the prescription drug regimen.

(C) The patient has tried the required prescription drug while under their current or a previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action and such prescription drug was discontinued due to a lack of efficacy or effectiveness, diminished effect, or an adverse event.

(D) The required prescription drug is not in the best interest of the patient, based upon medical appropriateness.

(E) The patient is stable on a prescription drug selected by their health care provider for the medical condition under consideration.

(3) Upon the granting of a step therapy override determination, the health plan issuer or utilization review organization shall authorize coverage for the prescription drug prescribed by the patient’s treating healthcare provider, provided such prescription drug is a covered prescription drug under such policy or contract.

(4) This section shall not be construed to prevent:

(A) A health plan issuer or utilization review organization from requiring a patient to try an AB-Rated generic equivalent prior to providing coverage for the equivalent branded prescription drug.

(B) A health care provider from prescribing a prescription drug that is determined to be medically appropriate.

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§33-25A-8p. Lyme disease to be covered by all health insurance policies.

A health maintenance organization issuing coverage in this state pursuant to the provisions of this article shall make available as benefits to all subscribers and members coverage on an expense-incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation shall provide coverage for long-term antibiotic therapy for a patient with Lyme disease when determined to be medically necessary and ordered by a licensed physician after making a thorough evaluation of the patient's symptoms, diagnostic test results, or response to treatment.

WV Legislature

§33-25A-8q. Coverage for amino acid-based formulas.

(a) A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that is subject to this article shall provide coverage, through the age of 20, for amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state pursuant to either §30-3-1 et seq. or §30-14-1 et seq. of this code:

(1) Immunoglobulin E and Nonimmunoglobulin E-medicated allergies to multiple food proteins;

(2) Severe food protein-induced enterocolitis syndrome;

(3) Eosinophilic disorders as evidenced by the results of a biopsy; and

(4) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract (short bowel).

(b) The coverage required by §33-25A-8p(a) of this code shall include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary, regardless of methodology of delivery.

(c) For purposes of this section, “medically necessary foods” or “medical foods” shall mean prescription amino acid-based elemental formulas obtained through a pharmacy: Provided, That these foods are specifically designated and manufactured for the treatment of severe allergic conditions or short bowel.

(d) The provisions of this section shall not apply to persons with an intolerance for lactose or soy.

WV Legislature

§33-25A-8r. Substance use disorder.

(a) As used in this section, the following words have the following meanings:

(1) "Concurrent review" means inpatient care is reviewed as it is provided. Medically qualified reviewers monitor appropriateness of the care, the setting, and patient progress, and, as appropriate, the discharge plans.

(2) "Covered person" means an individual, other than a Medicaid recipient, for whom coverage has been provided pursuant to the provisions of this article.

(3) "Insurance Commissioner" means the person appointed pursuant to the provisions of §33-2-1 of this code.

(4) "Health benefit plan" means the same as that term is defined in §33-24-7p of this code.

(5) "Health plan issuer" means the same as that term is defined in §33-24-7p of this code.

(6) "Physician" or "psychiatrist" means a person licensed pursuant to the provisions of either §30-3-1 et seq. or §30-14-1 et seq. of this code.

(7) "Psychologist" means a person licensed pursuant to the provisions of §30-21-1 et seq. of this code.

(8) "Substance use disorder" means the same as that term is defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and shall include substance use withdrawal.

(b) A health benefit plan offered by a health plan issuer that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this state, or approved for issuance or renewal by the Insurance Commissioner, on or after January 1, 2019, shall provide benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities at the same level as other medical benefits offered by the health benefit plan offered by a health plan insurer.

(c) The services for the treatment of substance use disorder shall be:

(1) Prescribed by a physician or psychiatrist licensed pursuant to the provisions of §30-3-1 et seq. or §30-14-1 et seq. of this code or recommended by a psychologist licensed pursuant to the provisions of §30-21-1 et seq. of this code; and

(2) Provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise state-approved facilities, as required by this code.

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(d) The inpatient and outpatient treatment of substance use disorders shall be provided when determined medically necessary by the covered person's physician, psychologist, or psychiatrist. The facility shall notify the insurer of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment. If there is no in-network facility immediately available for a covered person, a health benefit plan offered by a health plan issuer shall provide necessary exceptions to its network to ensure admission in a treatment facility within 72 hours. If a covered person is being treated at an out-of-network facility and an in-network facility becomes available during the course of the treatment plan, an insurer may transfer the covered person to the in-network facility.

(e) Providers of treatment for substance use disorders to persons covered under a covered contract shall not require prepayment of medical expenses during this 180 days in excess of applicable copayment, deductible, or coinsurance as provided in the contract.

(f) The benefits for outpatient visits may be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

(g)(1) If an insurer determines that continued inpatient care in a facility is no longer medically necessary, the insurer shall, within 72 hours, provide written notice to the covered person and the covered person's physician of its decision and the right to file for an expedited review of an adverse decision.

(2) The insurer shall review and make a determination with respect to the internal appeal within 72 hours and communicate that determination to the covered person and the covered person's physician.

(3) If the determination is to uphold the denial, the covered person and the covered person's physician have the right to file an expedited external appeal with an independent review organization. An independent utilization review organization shall make a determination within 72 hours.

(4) If the insurer's determination is upheld and it is determined continued inpatient care is not medically necessary, the insurer remains responsible to provide benefits for the inpatient care through the day following the date the determination is made and the covered person shall only be responsible for any applicable copayment, deductible, and coinsurance for the stay through that date as applicable under the contract.

(5) The covered person shall not be discharged or released from the inpatient facility until all internal appeals and independent utilization review organization appeals are exhausted. For any costs incurred after the day following the date of determination until the day of discharge, the covered person is only responsible for any applicable cost-sharing, and any additional charges shall be paid by the facility or provider.

(h) The Insurance Commissioner shall propose rules in accordance with the provisions of §29A-3-1 et seq. of this code to develop a procedure for an expedited review of an adverse

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decision as set forth in this section. The Legislature finds that for the purposes of §29A-3-15 of this code, an emergency exists requiring the promulgation of an emergency rule to respond to the growing need in our state for substance abuse treatment.

(i)(1) The benefits for the first five days of intensive outpatient or partial hospitalization services shall be provided without any retrospective review of medical necessity, and medical necessity shall be determined by the covered person's physician.

(2) The benefits beginning day six and every six days thereafter of intensive outpatient or partial hospitalization services is subject to a concurrent review of the medical necessity of the services.

(j) Medical necessity review shall use an evidence-based and peer-reviewed clinical review tool. This tool shall be developed by the Insurance Commissioner. The Insurance Commissioner shall propose rules for legislative approval in accordance with the provisions of §29A-3-1 et seq. of this code to develop the tool.

(k) The benefits for outpatient prescription drugs to treat substance use disorder shall be provided when determined medically necessary by the covered person's physician or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements.

(l) The days per plan year of benefits shall be computed based on inpatient days. One or more unused inpatient days may be exchanged for two outpatient visits. All extended outpatient services such as partial hospitalization and intensive outpatient, shall be considered inpatient days for the purpose of the visit-to-day exchange provided in this subsection.

(m) Except as provided in this section, the benefits and cost-sharing shall be provided to the same extent as for any other medical condition covered under the contract.

(n) The benefits required by this section are to be provided to all covered persons with a diagnosis of substance use disorder. The presence of additional related or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this section.

(o) The provisions of this section apply to all insurance contracts in which the insurer has reserved the right to change the premium.

WV Legislature

§33-25A-8s. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to them in this section unless the context clearly indicates otherwise:

"Episode of care" means a specific medical problem, condition, or specific illness being managed including tests, procedures, and rehabilitation initially requested by the health care practitioner, to be performed at the site of service, excluding out-of-network care: *Provided*, That any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

"National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the United States Department of Health and Human Services;

"Prior authorization" means obtaining advance approval from a health maintenance organization about the coverage of a service or medication.

(b) The health maintenance organization shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. These forms shall be placed in an easily identifiable and accessible place on the health maintenance organization's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

(1) Include instructions for the submission of clinical documentation;

(2) Provide an electronic notification to the health care provider confirming receipt of the prior authorization request for forms submitted electronically;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the health maintenance organization requires a prior authorization. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list shall be updated at least quarterly to ensure that the list remains current;

(4) Inform the patient if the health maintenance organization requires a plan member to use step therapy protocols. This shall be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the health maintenance organization and the step therapy has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by July 1, 2024.

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(c) Provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider.

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health maintenance organization shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request, except that the health maintenance organization shall respond to the prior authorization request within two business days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or

(2) In the opinion of a health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the health maintenance organization shall identify all deficiencies, and within two business days from the day on the electronic receipt of the prior authorization request, return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the day the return request is received by the health care practitioner. The health insurer shall render a decision within two business days after receipt of the additional information submitted by the health care provider. If the health care provider fails to submit the additional information, the prior authorization is considered denied and a new request shall be submitted.

(f) If the health maintenance organization wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by a health maintenance organization is carried over to all other managed care organizations, health insurers, and the Public Employees Insurance Agency for three months if the services are provided within the state.

(h) The health maintenance organization shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the health maintenance organization and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner, similar in specialty, education, and background. The health maintenance organization's medical

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director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business days from the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization may not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization shall be obtained.

(2) If the approval of a prior authorization requires a medication substitution, the substituted medication shall be as required under §30-5-1 *et seq*. of this code.

(k) If a health care practitioner has performed an average of 30 procedures per year and in a six-month time period during that year has received a 90 percent final prior approval rating, the health maintenance organization may not require the health care practitioner to submit a prior authorization for at least the next six months or longer if the insurer allows: *Provided*, That at the end of the six-month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time period equal to the previously granted time period, or longer if the insurer allows. This exemption is subject to internal auditing, at any time, by the health maintenance organization and may be rescinded if the health maintenance organization determines the health care practitioner is not performing services or procedures in conformity with the health maintenance organization's benefit plan, it identifies substantial variances in historical utilization, or identifies other anomalies based upon the results of the health maintenance organization's internal audit. The insurer shall provide a health care practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit an insurer from requiring prior authorization for an experimental treatment, non-covered benefit, or any out-of-network service or procedure. This subsection shall not apply to pharmaceutical medications or services or procedures where the benefit maximums or minimums have been required by statute or policy of the Bureau for Medical Services as it relates to the Medicaid Program.

(l) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior

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authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, the name of each physician whose gold card status was revoked and the reason for revocation.

(n) The Insurance Commissioner may assess a civil penalty for a violation of this section pursuant to §33-3-11 of this code.

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§33-25A-8t. Fairness in Cost-Sharing Calculation.

(a) As used in this section:

"Cost sharing" means any copayment, coinsurance, or deductible required by or on behalf of an insured in order to receive a specific health care item or service covered by a health plan.

"Drug" means the same as the term is defined in §30-5-4 of this code.

"Person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, nonprofit corporation, unincorporated organization, or government or governmental subdivision or agency.

"Pharmacy benefits manager" means the same as that term is defined in §33-51-3 of this code.

(b) When calculating an insured's contribution to any applicable cost sharing requirement, including, but not limited to, the annual limitation on cost sharing subject to 42 U.S.C. § 18022(c) and 42 U.S.C. § 300gg-6(b):

(1) An insurer shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person; and

(2) A pharmacy benefits manger shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person.

(c) The commissioner is authorized to propose rules for legislative approval in accordance with §29A-3-1 *et seq*. of this code, to implement the provisions of this section.

(d) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(e) If under federal law application of subsection (b) of this section would result in Health Savings Account ineligibility under Section 223 of the Internal Revenue Code, this requirement shall apply only for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code: *Provided*, That with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, the requirements of subsection (b) of this section shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

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§33-25A-8u. Mental health parity.

(a) As used in this section, the following words and phrases have the meaning given them in this section unless the context clearly indicates otherwise:

To the extent that coverage is provided "behavioral health, mental health, and substance use disorder" means a condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of:

(1) The International Statistical Classification of Diseases and Related Health Problems;

(2) The Diagnostic and Statistical Manual of Mental Disorders; or

(3) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood; and

Includes autism spectrum disorder: *Provided*, That any service, even if it is related to the behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall be reviewed as a medical claim and undergo all utilization review as applicable.

(b) The carrier is required to provide coverage for the prevention of, screening for, and treatment of behavioral health, mental health, and substance use disorders that is no less extensive than the coverage provided for any physical illness and that complies with the requirements of this section. This screening shall include, but is not limited to, unhealthy alcohol use for adults, substance use for adults and adolescents, and depression screening for adolescents and adults.

(c) The carrier shall:

(1) Include coverage and reimbursement for behavioral health screenings using a validated screening tool for behavioral health, which coverage and reimbursement is no less extensive than the coverage and reimbursement for the annual physical examination;

(2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR §146.136(c)(4), or any successor regulation, regarding any limitations that are not expressed numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to the limitations and examples listed in 45 CFR §146.136(c)(4)(ii) and (c)(4)(iii), or any successor regulation and 78 FR 68246, include the methods by which the carrier establishes and maintains its provider network and responds to deficiencies in the ability of its networks to provide timely access to care;

(3) Comply with the financial requirements and quantitative treatment limitations specified in 45 CFR §146.136(c)(2) and (c)(3), or any successor regulation;

(4) Not apply any nonquantitative treatment limitations to benefits for behavioral health,

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mental health, and substance use disorders that are not applied to medical and surgical benefits within the same classification of benefits;

(5) Establish procedures to authorize treatment with a nonparticipating provider if a covered service is not available within established time and distance standards and within a reasonable period after service is requested, and with the same coinsurance, deductible, or copayment requirements as would apply if the service were provided at a participating provider, and at no greater cost to the covered person than if the services were obtained at, or from a participating provider;

(6) If a covered person obtains a covered service from a nonparticipating provider because the covered service is not available within the established time and distance standards, reimburse treatment or services for behavioral health, mental health, or substance use disorders required to be covered pursuant to this subsection that are provided by a nonparticipating provider using the same methodology that the carrier uses to reimburse covered medical services provided by nonparticipating providers and, upon request, provide evidence of the methodology to the person or provider.

(d) If the carrier offers a plan that does not cover services provided by an out-of-network provider, it may provide the benefits required in subsection (c) of this section if the services are rendered by a provider who is designated by and affiliated with the carrier only if the same requirements apply for services for a physical illness.

(e) In the event of a concurrent review for a claim for coverage of services for the prevention of, screening for, and treatment of behavioral health, mental health, and substance use disorders, the service continues to be a covered service until the carrier notifies the covered person of the determination of the claim.

(f) Unless denied for nonpayment of premium, a denial of reimbursement for services for the prevention of, screening for, or treatment of behavioral health, mental health, and substance use disorders by the carrier must include the following language:

(1) A statement explaining that covered persons are protected under this section, which provides that limitations placed on the access to mental health and substance use disorder benefits may be no greater than any limitations placed on access to medical and surgical benefits;

(2) A statement providing information about the Division of Consumer Services of the Office of the West Virginia Insurance Commissioner if the covered person believes his or her rights under this section have been violated; and

(3) A statement specifying that covered persons are entitled, upon request to the carrier, to a copy of the medical necessity criteria for any behavioral health, mental health, and substance use disorder benefit.

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(g) On or after June 1, 2021, and annually thereafter, the Insurance Commissioner shall submit a written report to the Joint Committee on Government and Finance that contains the following information regarding plans offered pursuant to this section:

(1) Data that demonstrates parity compliance for adverse determination regarding claims for behavioral health, mental health, or substance use disorder services and includes the total number of adverse determinations for such claims;

(2) A description of the process used to develop and select:

(A) The medical necessity criteria used in determining benefits for behavioral health, mental health, and substance use disorders; and

(B) The medical necessity criteria used in determining medical and surgical benefits;

(3) Identification of all nonquantitative treatment limitations that are applied to benefits for behavioral health, mental health, and substance use disorders and to medical and surgical benefits within each classification of benefits; and

(4)The results of analyses demonstrating that, for medical necessity criteria described in subdivision (2) of this subsection and for each nonquantitative treatment limitation identified in subdivision (3) of this subsection, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to benefits for behavioral health, mental health, and substance use disorders within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits.

(5) The Insurance Commissioner’s report of the analyses regarding nonquantitative treatment limitations shall include at a minimum:

(A) Identifying factors used to determine whether a nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected;

(B) Identifying and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation;

(C) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the written processes and strategies used to apply each nonquantitative treatment limitation for benefits for behavioral health, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to design and apply each nonquantitative treatment limitation, as written, and the written processes and strategies used to apply each nonquantitative

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treatment limitation for medical and surgical benefits;

(D) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for benefits for behavioral health, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(E) Disclose the specific findings and conclusions reached by the Insurance Commissioner that the results of the analyses indicate that each health benefit plan offered pursuant to this section complies with subsection (c) of this section.

(h) The Insurance Commissioner shall adopt legislative rules to comply with the provisions of this section. These rules shall specify the information and analyses that carriers shall provide to the Insurance Commissioner necessary for the commissioner to complete the report described in subsection (g) of this section and shall delineate the format in which carriers shall submit such information and analyses. These rules or amendments to rules shall be proposed pursuant to the provisions of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the Legislature during its regular session in the year 2021. The rules shall require that each carrier first submit the report to the Insurance Commissioner no earlier than one year after the rules are promulgated, and any year thereafter during which the carrier makes significant changes to how it designs and applies medical management protocols.

(i) This section is effective for policies, contracts, plans or agreements, beginning on or after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(j) The Insurance Commissioner shall enforce this section and may conduct a financial examination of the carrier to determine if it is in compliance with this section, including, but not limited to, a review of policies and procedures and a sample of mental health claims to determine these claims are treated in parity with medical and surgical benefits. The results of this examination shall be reported to the Legislature. If the Insurance Commissioner determines that the carrier is not in compliance with this section, the Insurance Commissioner may fine the carrier in conformity with the fines established in the legislative rule.

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§33-25A-8v. Incorporation of the Health Benefit Plan Access and Adequacy Act.

The provisions of the Health Benefit Plan Network Access and Adequacy Act codified at §33-55-1 *et seq.* of this code is made applicable to the provisions of this article.

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§33-25A-8w. Incorporation of the coverage for 12-month refill for contraceptive drugs.

The provision requiring coverage for 12-month refill for contraceptive drugs codified at §33-58-1 of this code is made applicable to the provisions of this article.

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§33-25A-8x. Copayments for certain services.

(a) A health maintenance organization issuing coverage in this state pursuant to the provisions of this article may not impose a copayment, coinsurance, or office visit deductible amount charged to a subscriber or member for services rendered for each date of service by a licensed occupational therapist, licensed occupational therapist assistant, licensed speech-language pathologist, licensed speech-pathologist assistant, licensed physical therapist, or a licensed physical therapist assistant that is greater than the copayment, coinsurance, or office visit deductible amount charged to the subscriber or member for the services of a primary care physician or an osteopathic physician.

(b) The policy, provision, contract, plan, or agreement subject to this article shall clearly state the availability of occupational therapy, speech-language therapy, and physical therapy coverage and all related limitations, conditions, and exclusions.

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§33-25A-8y. Coverage of emergency medical services to triage and transport to alternative destination or treat in place.

(a) The following terms are defined:

(1) "911 call" means a communication indicating that an individual may need emergency medical services;

(2) "Alternative destination" means a lower-acuity facility that provides medical services, including without limitation:

(A) A federally-qualified health center;

(B) An urgent care center;

(C) A rural health clinic;

(D) A physician office or medical clinic as selected by the patient; and

(E) A behavioral or mental health care facility including, without limitation, a crisis stabilization unit.

"Alternative destination" does not include a:

(A) Critical access hospital;

(B) Dialysis center;

(C) Hospital;

(D) Private residence; or

(E) Skilled nursing facility;

(3) "Emergency medical services agency" means any agency licensed under §16-4C-6a of this code to provide emergency medical services: *Provided*, That rotary and fixed wing air ambulances are specifically excluded from the definition of an emergency medical services agency;

(4) "Medical command" means the issuing of orders by a physician from a medical facility to emergency medical services personnel for the purpose of providing appropriate patient care; and

(5) "Telehealth services" means the use of synchronous or asynchronous telecommunications technology or audio-only telephone calls by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related

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education; public health services; and health administration. The term does not include e-mail messages or facsimile transmissions.

(b) An insurer which issues or renews a health insurance policy on or after January 1, 2025, shall provide coverage for:

(1) An emergency medical services agency to:

(A) Treat an enrollee in place if the ambulance service is coordinating the care of the enrollee through telehealth services with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint;

(B) Triage or triage and transport an enrollee to an alternative destination if the ambulance service is coordinating the care of the enrollee through telehealth services with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint; or

(C) An encounter between an ambulance service and enrollee that results in no transport of the enrollee if:

(i) The enrollee declines to be transported against medical advice; and

(ii) The emergency medical services agency is coordinating the care of the enrollee through telehealth services or medical command with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint.

(c) The coverage under this section:

(1) Only includes emergency medical services transportation to the treatment location;

(2) Is subject to the initiation of response, triage, and treatment as a result of a 911 call that is documented in the records of the emergency medical services agency;

(3) Is subject to deductibles or copayment requirements of the policy, contract, or plan;

(4) Does not diminish or limit benefits otherwise allowable under a health benefit plan, even if the billing claims for medical or behavioral health services overlap in time that is billed by the ambulance service also providing care; and

(5) Does not include rotary or fixed wing air ambulance services.

(d) The reimbursement rate for an emergency medical services agency that triages, treats, and transports a patient to an alternative destination, or triages, treats, and does not transport a patient, if the patient declines to be transported against medical advice, if the ambulance service is coordinating the care of the enrollee through medical command or telemedicine with a physician for a medical-based complaint, or with a behavioral health

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specialist for a behavioral-based complaint under this section, shall be reimbursed at the same rate as if the patient were transported to an emergency room of a facility provider.

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§33-25A-9. Annual report.

Every health maintenance organization shall comply with and is subject to the provisions of §33-4-14 relating to filing of financial statements with the commissioner and the national association of Insurance Commissioners. The annual financial statement required by that section shall include, but not be limited to, the following:

(a) A statutory financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent certified public accountant, reflecting at least: (i) All prepayment and other payments received for health care services rendered; (ii) expenditures to all providers, by classes or groups of providers, and insurance companies or nonprofit health service plan corporations engaged to fulfill obligations arising out of the health maintenance contract; (iii) expenditures for capital improvements, or additions thereto, including, but not limited to, construction, renovation or purchase of facilities and capital equipment; and (iv) the organization's fidelity bond;

(b) The number of new enrollees enrolled during the year, the number of enrollees as of the end of the year and the number of enrollees terminated during the year on a form prescribed by the commissioner;

(c) A summary of information compiled pursuant to §33-25A-4(1)(c) in such form as may be required by the Department of Human Services or a nationally recognized accreditation and review organization or as the commissioner may by rule require;

(d) A report of the names and residence addresses of all persons set forth in §33-25A-3(1)(c) who were associated with the health maintenance organization during the preceding year, and the amount of wages, expense reimbursements or other payments to those individuals for services to the health maintenance organization, including a full disclosure of all financial arrangements during the preceding year required to be disclosed pursuant to §33-25A-3(1)(c); and

(e) Any other information relating to the performance of the health maintenance organization as is reasonably necessary to enable the commissioner to carry out his or her duties under this article.

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§33-25A-10. Information to enrollees.

Every health maintenance organization or its representative shall annually, before April 1, provide to its enrollees a summary of: Its most recent annual financial statement, including a balance sheet and statement of receipts and disbursements; a description of the health maintenance organization, its basic health care services, its facilities and personnel, any material changes therein since the last report, the current evidence of coverage, and a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints: Provided, That with respect to enrollees who have been enrolled through contracts between a health maintenance organization and an employer, the health maintenance organization shall be deemed to have satisfied the requirement of this section by providing the requisite summary to each enrolled employee: Provided, however, That with respect to Medicaid recipients enrolled under a group contract between a health maintenance organization and the governmental agency responsible for administering the Medicaid program, the health maintenance organization shall be deemed to have satisfied the requirement of this section by providing the requisite summary to each local office of the governmental agency responsible for administering the Medicaid program for inspection by enrollees of the health maintenance organization.

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§33-25A-11. Open enrollment period.

(1) Once a health maintenance organization has been in operation at least five years, or has enrollment of not less than fifty thousand persons, the health maintenance organization shall, in any year following a year in which the health maintenance organization has achieved an operating surplus, maintain an open enrollment period of at least thirty days during which time the health maintenance organization shall, within the limits of its capacity, accept individuals in the order in which they apply without regard to preexisting illness, medical conditions or degree of disability except for individuals who are confined to an institution because of chronic illness or permanent injury: Provided, That no health maintenance organization shall be required to continue an open enrollment period after such time as enrollment pursuant to the open enrollment period is equal to three percent of the health maintenance organization's net increase in enrollment during the previous year.

(2) Where a health maintenance organization demonstrates to the satisfaction of the commissioner that it has a disproportionate share of high-risk enrollees and that, by maintaining open enrollment, it would be required to enroll so disproportionate a share of high-risk enrollees as to jeopardize its economic viability, the commissioner may:

(a) Waive the requirement for open enrollment for a period of not more than three years; or

(b) Authorize the organization to impose any underwriting restrictions upon open enrollment as are necessary: (i) To preserve its financial stability; (ii) to prevent excessive adverse selection by prospective enrollees; or (iii) to avoid unreasonably high or unmarketable charges for enrollee coverage of health services. A health maintenance organization may receive more than one waiver or authorization.

WV Legislature

§33-25A-12. Grievance procedure.

(a) A health maintenance organization shall establish and maintain a grievance procedure, which has been approved by the Commissioner, to provide adequate and reasonable procedures for the expeditious resolution of written grievances initiated by enrollees concerning any matter relating to any provisions of the organization's health maintenance contracts, including, but not limited to, claims regarding the scope of coverage for health care services; denials, cancellations or nonrenewals of enrollee coverage; observance of an enrollee's rights as a patient; and the quality of the health care services rendered.

(b) A detailed description of the HMO's subscriber grievance procedure shall be included in all group and individual contracts as well as any certificate or member handbook provided to subscribers. This procedure shall be administered at no cost to the subscriber. An HMO subscriber grievance procedure shall include the following:

(1) Both informal and formal steps shall be available to resolve the grievance. A grievance is not considered formal until a written grievance is executed by the subscriber or completed on forms prescribed and received by the HMO;

(2) Each HMO shall designate at least one grievance coordinator who is responsible for the implementation of the HMO's grievance procedure;

(3) Phone numbers shall be specified by the HMO for the subscriber to call to present an informal grievance or to contact the grievance coordinator. Each phone number shall be toll free within the subscriber's geographic area and provide reasonable access to the HMO without undue delays. There must be an adequate number of phone lines to handle incoming grievances;

(4) An address shall be included for written grievances;

(5) Each level of the grievance procedure shall have some person with problem-solving authority to participate in each step of the grievance procedure;

(6) The HMO shall process the formal written subscriber grievance through all phases of the grievance procedure in a reasonable length of time not to exceed sixty days, unless the subscriber and HMO mutually agree to extend the time frame. If the complaint involves the collection of information outside the service area, the HMO has thirty additional days to process the subscriber complaint through all phases of the grievance procedure. The time limitations prescribed in this subdivision requiring completion of the grievance process within sixty days shall be tolled after the HMO has notified the subscriber, in writing, that additional information is required in order to properly complete review of the grievance. Upon receipt by the HMO of the additional information requested, the time for completion of the grievance process set forth in this subdivision shall resume;

(7) The subscriber grievance procedure shall state that the subscriber has the right to

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appeal to the Commissioner. There shall be the additional requirement that subscribers under a group contract between the HMO and a department or division of the state shall first appeal to the state agency responsible for administering the relevant program, and if either of the two parties are not satisfied with the outcome of the appeal, they may then appeal to the Commissioner. The HMO shall provide to the subscriber written notice of the right to appeal upon completion of the full grievance procedure and supply the Commissioner with a copy of the final decision letter;

(8) The HMO shall have physician involvement in reviewing medically related grievances. Physician involvement in the grievance process should not be limited to the subscriber's primary care physician, but may include at least one other physician;

(9) The HMO shall offer to meet with the subscriber during the formal grievance process. The location of the meeting shall be at the administrative offices of the HMO within the service area or at a location within the service area which is convenient to the subscriber;

(10) The HMO may not establish time limits of less than one year from the date of occurrence for the subscriber to file a formal grievance;

(11) Each HMO shall maintain an accurate record of each formal grievance. Each record shall include the following: A complete description of the grievance, the subscriber's name and address, the provider's name and address and the HMO's name and address; a complete description of the HMO's factual findings and conclusions after completion of the full formal grievance procedure; a complete description of the HMO's conclusions pertaining to the grievance as well as the HMO's final disposition of the grievance; and a statement as to which levels of the grievance procedure the grievance has been processed and how many more levels of the grievance procedure are remaining before the grievance has been processed through the HMO's entire grievance procedure.

(c) Copies of the grievances and the responses to the grievances shall be available to the Commissioner and, subject to state and federal privacy laws, to the public for inspection for five years.

(d) Any subscriber grievance in which time is of the essence shall be handled on an expedited basis, such that a reasonable person would believe that a prevailing subscriber would be able to realize the full benefit of a decision in his or her favor.

(e) Each health maintenance organization shall submit to the Commissioner an annual report in a form prescribed by the Commissioner which describes the grievance procedure and contains a compilation and analysis of the grievances filed, their disposition, and their underlying causes.

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§33-25A-13. Investments.

With the exception of investments otherwise made in accordance with this article, the investable funds of a health maintenance organization shall be invested only in securities or other investments permitted by the laws of this state for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the commissioner may permit.

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§33-25A-14. Prohibited advertising practices.

(a) No health maintenance organization, or representative of a health maintenance organization, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. No advertising may be used until it has been approved by the Commissioner. Advertising which has not been disapproved by the Commissioner within sixty days of filing shall be considered approved. For purposes of this article:

(1) A statement or item of information shall be considered to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health maintenance organization;

(2) A statement or item of information shall be considered to be misleading, whether or not it may be literally untrue if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health maintenance organization, if the benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist;

(3) An evidence of coverage shall be considered to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, is such as to cause a reasonable person, not possessing special knowledge regarding health maintenance organizations, and evidences of coverage therefor, to expect benefits, services or other advantages which the evidence of coverage does not provide or which the health maintenance organization issuing the evidence of coverage does not regularly make available for enrollees covered under the evidence of coverage; and

(4) The Commissioner may propose rules for legislative approval in accordance with article three, chapter twenty-nine-a of this code to further define practices which are untrue, misleading or deceptive.

(b)(1) No health maintenance organization may use in its name, contracts, logo or literature any of the words "insurance", "casualty", "surety", "mutual" or any other words which are descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state: Provided, That when a health maintenance organization has contracted with an insurance company for any coverage permitted by this article, it may so state; and

(2) Only a person that has been issued a certificate of authority under this article may use the words "health maintenance organization" or the initials "HMO" in its name, contracts, logo or literature to imply, directly or indirectly, that it is a health maintenance organization or hold itself out to be a health maintenance organization.

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(c)(1) No agent of a health maintenance organization or person selling enrollments in a health maintenance organization shall sell an enrollment in a health maintenance organization unless the agent or person shall first disclose in writing to the prospective purchaser the following information using the following exact terms in bold print: "Services offered", including any exclusions or limitations; "full cost", including copayments; "facilities available"; "transportation services"; "disenrollment rate"; and "staff", including the names of all full-time staff physicians, consulting specialists, hospitals and pharmacies associated with the health maintenance organization. In any home solicitation, any three-day cooling-off period applicable to consumer transactions generally applies in the same manner as consumer transactions.

(2) The form disclosure statement shall not be used in sales until it has been approved by the Commissioner or submitted to the Commissioner for sixty days without disapproval.

(d) No contract with an enrollee shall prohibit an enrollee from canceling his or her enrollment at any time for any reason except that the contract may require thirty days' notice to the health maintenance organization.

(e) Any person who, in connection with an enrollment, violates any provision of this section may be held liable for an amount equivalent to one year's subscription rate, plus costs and a reasonable attorney's fee.

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§33-25A-14a. Other prohibited practices.

(a) No health maintenance organization may cancel or fail to renew the coverage of an enrollee except for: (1) Failure to pay the charge for health care coverage; (2) termination of the health maintenance organization; (3) termination of the group plan; (4) enrollee moving out of the area served; (5) enrollee moving out of an eligible group; or (6) other reasons established in rules promulgated by the Commissioner. No health maintenance organization shall use any technique of rating or grouping to cancel or fail to renew the coverage of an enrollee. An enrollee shall be given thirty days' notice of any cancellation or nonrenewal and the notice shall include the reasons for the cancellation or nonrenewal: Provided, That each enrollee moving out of an eligible group shall be granted the opportunity to enroll in the health maintenance organization on an individual basis. A health maintenance organization may not disenroll an enrollee for nonpayment of copayments unless the enrollee has failed to make payment in at least three instances over any twelve-month period: Provided, however, That the enrollee may not be disenrolled if the disenrollment would constitute abandonment of a patient. Any enrollee wrongfully disenrolled shall be reenrolled.

(b) The providers of a health maintenance organization who provide health care services and the health maintenance organization shall not have recourse against enrollees for amounts above those specified in the evidence of coverage as the periodic prepayment or copayment for health care services.

(c) No health maintenance organization shall enroll more than three hundred thousand persons in this state: Provided, That a health maintenance organization may petition the Commissioner to exceed an enrollment of three hundred thousand persons and, upon notice and hearing, good cause being shown and a determination made that an increase would be beneficial to the subscribers, creditors and stockholders of the organization or would otherwise increase the availability of coverage to consumers within the state, the Commissioner may, by written order only, allow the petitioning organization to exceed an enrollment of three hundred thousand persons.

(d) No health maintenance organization shall discriminate in enrollment policies or quality of services against any person on the basis of race, sex, age, religion, place of residence, source of payment or, with respect to enrollment in group policies, health status: Provided, That differences in rates based on valid actuarial distinctions, including distinctions relating to age and sex, shall not be considered discrimination in enrollment policies.

(e) Any person who, in connection with an enrollment, violates any provision of this section may be held liable for an amount equivalent to one year's subscription rate, plus costs and a reasonable attorney's fee.

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§33-25A-15. Agent licensing and appointment required; regulation of marketing.

(1) Health maintenance organizations are subject to the provisions of article twelve of this chapter.

(2) With respect to individual and group contracts covering fewer than twenty-five subscribers, after a subscriber signs a health maintenance organization enrollment application and before the health maintenance organization may process the application changing or initiating the subscriber coverage, each health maintenance organization must verify in writing, in a form prescribed by the commissioner, the intent and desire of the individual subscriber to join the health maintenance organization. The verification shall be conducted by someone outside the health maintenance organization marketing department and shall show that:

(a) The subscriber intends and desires to join the health maintenance organization;

(b) If the subscriber is a Medicare or Medicaid recipient, the subscriber understands that by joining the health maintenance organization he or she will be limited to the benefits provided by the health maintenance organization, and Medicare or Medicaid will pay the health maintenance organization for the subscriber coverage;

(c) The subscriber understands the applicable restrictions of health maintenance organizations especially that he or she must use the health maintenance organization providers and secure approval from the health maintenance organization to use health care providers outside the plan; and

(d) If the subscriber is a member of a health maintenance organization, the subscriber understands that he or she is transferring to another health maintenance organization.

(3) The health maintenance organization shall not pay a commission, fee, money or any other form of scheduled compensation to any health insurance agent until the subscriber's application has been processed and the health maintenance organization has confirmed the subscriber's enrollment by written notice in the form prescribed by the commissioner. The confirmation notice shall be accompanied by the evidence of coverage required by section eight of this article and shall confirm:

(a) The subscriber's transfer from his or her existing coverage (i.e. from Medicare, Medicaid, another health maintenance organization, etc.) to the new health maintenance organization; and

(b) The date enrollment begins and when benefits will be available.

(4) The enrollment process shall be considered complete seven days after the health maintenance organization mails the confirmation notice and evidence of coverage to the subscriber. Each health maintenance organization is directly responsible for enrollment abuses.

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(5) The commissioner may, in his or her discretion, after notice and hearing, promulgate rules as are necessary to regulate marketing of health maintenance organizations by persons compensated directly or indirectly by the health maintenance organizations. When necessary the rules may prohibit door-to-door solicitations, may prohibit commission sales, and may provide for such other proscriptions and other rules as are required to effectuate the purposes of this article.

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§33-25A-16. Powers of insurers and hospital and medical service corporations.

(1) An insurance company licensed in this state or a hospital or medical service corporation authorized to do business in this state, after applying for and receiving a certificate of authority as a health maintenance organization, may through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this article. Notwithstanding any other law to the contrary, any two or more insurance companies, hospital or medical service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is considered to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(2) Notwithstanding any provision of insurance and hospital or medical service corporation laws, an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under the contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

WV Legislature

§33-25A-17. Examinations.

(a) The Commissioner may make an examination of the affairs of any health maintenance organization and providers with whom the organization has contracts, agreements or other arrangements as often as he or she considers it necessary for the protection of the interests of the people of this state but not less frequently than once every five years.

(b) The Commissioner may contract with the Department of Human Services, any entity which has been accredited by a nationally recognized accrediting organization and has been approved by the Commissioner to make examinations concerning the quality of health care services of any health maintenance organization and providers with whom the organization has contracts, agreements or other arrangements, or any entity contracted with by the Department of Human Services, as often as it considers necessary for the protection of the interests of the people of this state, but not less frequently than once every three years: *Provided*, That in making the examination, the Department of Human Services or the accredited entity shall use the services of persons or organizations with demonstrable expertise in assessing quality of health care.

(c) Every health maintenance organization and affiliated provider shall submit its books and records to the examinations and in every way facilitate them. For the purpose of examinations, the Commissioner and the Department of Human Services have all powers necessary to conduct the examinations, including, but not limited to, the power to issue subpoenas, the power to administer oaths to and examine the officers and agents of the health maintenance organization and the principals of the providers concerning their business.

(d) The health maintenance organization and any other entity subject to examination pursuant to this article are subject to the provisions of sections four, five, six, seven, eight and nine, article two of this chapter in regard to the expense and conduct of examinations.

(e) In lieu of the examination, the Commissioner may accept the report of an examination made by other states.

(f) The expenses of an examination assessing quality of health care under subsection (b) of this section and section seventeen-a of this article shall be reimbursed pursuant to subsection (n), section nine, article two of this chapter.

WV Legislature

§33-25A-17a. Quality assurance.

(a) Each health maintenance organization shall have in writing a quality assurance program that describes the program's objectives, organization and problem solving activities.

(b) The scope of the quality assurance program shall include, at a minimum:

(1) Organizational arrangements and responsibilities for quality management and improvement processes;

(2) A documented utilization management program;

(3) Written policies and procedures for credentialing and recredentialing physicians and other licensed providers who fall under the scope of authority of the health maintenance organization;

(4) A written policy that addresses enrollee's rights and responsibilities;

(5) The adoption of practice guidelines for the use of preventive health services; and

(6) Any other criteria deemed necessary by the commissioner.

(c) As a condition of doing business in this state, each health maintenance organization which has been in existence for at least three years shall apply for and submit to an accreditation examination to be performed by a nationally recognized accreditation and review organization approved by the commissioner. The accreditation and review organization must be experienced in health maintenance organization activities and in the appraisal of medical practice and quality assurance in a health maintenance organization setting: Provided, That in those instances where a health maintenance organization has timely applied for and reasonably pursued an accreditation examination, but the examination has not been completed, the health maintenance organization may, upon compliance with all other provisions of this article, engage in business in this state upon submission of proof to the commissioner of its application for review.

(d) Within thirty days of receipt of the written report of the accreditation and review organization by the health maintenance organization, the health maintenance organization shall submit a copy of this report to the commissioner.

(e) This section shall become effective on May 1, 1998.

WV Legislature

§33-25A-18. Suspension or revocation of certificate of authority.

(1) The commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this article if he or she finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organization document, in any material breach of contract with an enrollee, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section three of this article unless amendments to the submissions have been filed with an approval of the commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of premiums for health care services which do not comply with the requirements of section eight of this article;

(c) The health maintenance organization does not provide or arrange for basic health care services;

(d) The Department of Human Services or other accredited entity certifies to the commissioner that: (i) The health maintenance organization is unable to fulfill its obligations to furnish health care services as required under its contract with enrollees; or (ii) the health maintenance organization does not meet the requirements of subsection (l), section four of this article;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees or is otherwise determined by the commissioner to be in a hazardous financial condition;

(f) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under section six of this article;

(g) The health maintenance organization has failed to implement the grievance procedure required by section twelve of this article in a manner to reasonably resolve valid grievances;

(h) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees;

(j) The health maintenance organization has otherwise failed to substantially comply with this article;

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(k) The health maintenance organization has violated a lawful order of the commissioner; or

(l) The health maintenance organization has not complied with the requirements of section seventeen-a of this article.

(2) A certificate of authority shall be suspended or revoked only after compliance with the requirements of section twenty-one of this article.

(3) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of the suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

(4) When the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to terminate its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as he or she may find to be in the best interests of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

WV Legislature

§33-25A-19. Rehabilitation, liquidation or conservation of health maintenance organization.

Any rehabilitation, liquidation or conservation of a health maintenance organization shall be considered to be the rehabilitation, liquidation or conservation of an insurance company, shall be the exclusive remedy for rehabilitation, liquidation and conservation of an HMO as provided by this article and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation or conservation of insurance companies. The commissioner may apply for an order directing him or her to rehabilitate, liquidate or conserve a health maintenance organization upon any one or more grounds set out in the rehabilitation statutes or when, in his or her opinion, the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state.

WV Legislature

§33-25A-20. Regulations.

The commissioner may after notice and hearing promulgate reasonable rules and regulations in accordance with chapter twenty-nine-a of this code, as are necessary or proper to effectuate the purposes of this article and to prevent circumvention and evasion thereof.

WV Legislature

§33-25A-21. Administrative procedures.

(1) When the commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the health maintenance organization in writing specifically stating the grounds for denial, suspension or revocation and fixing a time of at least twenty days thereafter for a hearing on the matter.

(2) After such hearing, or upon the failure of the health maintenance organization to appear at such hearing, the commissioner shall take action as is deemed advisable on written findings which shall be mailed to the health maintenance organization. The action of the commissioner shall be subject to review. The court may modify, affirm or reverse the order of the commissioner in whole or in part.

(3) The provisions of the administrative procedures act, chapter twenty-nine-a of this code, shall apply to proceedings under this article to the extent that they are not in conflict with subsections (1) and (2) of this section.

WV Legislature

§33-25A-22. Fees.

Every health maintenance organization subject to this article shall pay to the Commissioner the following fees: For filing an application for a certificate of authority or amendment to the application, $200; for each renewal of a certificate of authority, the annual fee as provided in section thirteen, article three of this chapter; for each form filing and for each rate filing, the fee, as provided in section thirty-four, article six of this chapter; and for filing each annual report, $100. Fees charged under this section shall be for the purposes set forth in section thirteen, article three of this chapter.

WV Legislature

§33-25A-23. Penalties and enforcement.

(1) The Commissioner may, in lieu of suspension or revocation of a certificate of authority under section eighteen of this article, levy an administrative penalty in an amount not less than $100 nor more than $5,000, if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The Commissioner may augment this penalty by an amount equal to the sum that he or she calculates to be the damages suffered by enrollees or other members of the public.

(2) Any person who violates any provision of this article shall be guilty of a misdemeanor and, upon conviction thereof, shall be fined not less than $1,000 nor more than $10,000, or imprisoned in jail not more than one year, or both fined and imprisoned.

(3)(a) If the Commissioner has cause to believe that any violation of this article or rules promulgated pursuant to this article has occurred or is threatened, prior to the levy of a penalty or suspension or revocation of a certificate of authority, the Commissioner shall give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.

(b) Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in a manner the Commissioner determines appropriate under the circumstances. Enrollees shall be afforded notice by publication of proceedings under this subsection and shall be afforded the opportunity to intervene.

(4)(a) The Commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this article or regulations promulgated pursuant to this article.

(b) Within ten days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this article have occurred. The hearings shall be conducted pursuant to chapter twenty-nine-a of this code and judicial review shall be available as provided by chapter twenty-nine-a of this code.

(5) In the case of any violation of the provisions of this article or rules promulgated pursuant to this article, if the Commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (4) of this section, the Commissioner may institute a proceeding to obtain injunctive relief, or seek other appropriate relief, in the circuit court of the county of the principal place of business of the health maintenance organization.

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(6) Any enrollee of or resident of the service area of the health maintenance organization may bring an action to enforce any provision, standard or rule enforceable by the Commissioner. In the case of any successful action to enforce this article, or accompanying standards or rules the individual shall be awarded the costs of the action together with a reasonable attorney's fee as determined by the court.

WV Legislature

§33-25A-23a. Civil penalty imposed by commissioner.

No provider shall collect or attempt to collect from a health maintenance organization enrollee any money for services covered by the health maintenance organization. If a provider collects or attempts to collect from a health maintenance organization enrollee any money for services covered by the health maintenance organization, then the provider may be subjected to a civil money penalty to be imposed by the commissioner. Upon a determination that there is probable cause to believe that there has been a violation of this section, the commissioner may provide written notice to the alleged violator, stating the nature of the alleged violation and that failure to refund the amount of any improper billing within thirty days may result in imposition of a civil penalty pursuant to the provisions of this section. If the alleged violator fails to make a refund within thirty days, the commissioner shall issue a written notice of hearing stating the nature of the alleged violation and the time and place at which the alleged violator shall appear to show good cause why a civil penalty should not be imposed: Provided, That if the commissioner has previously found on three occasions that probable cause existed to support a violation, the alleged violator shall not be afforded the opportunity to make a refund before issuance of the notice of hearing for any subsequent violation.

If, after notice and hearing, the commissioner determines that a violation of this section has occurred, the commissioner may assess a civil penalty of not less than the amount charged the subscriber but not more than $1,000. Subsequent violations of this section result in fines of not more than $2,000. Any provider so assessed shall be notified of the assessment in writing and the notice shall specify the reasons for the assessment. Any provider may waive the right to a hearing and receive a reduction in penalties of twenty-five percent.

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§33-25A-24. Scope of provisions; applicability of other laws.

(a) Except as otherwise provided in this article, provisions of the insurance laws and provisions of hospital or medical service corporation laws are not applicable to any health maintenance organization granted a certificate of authority under this article. The provisions of this article shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this state except with respect to its health maintenance corporation activities authorized and regulated pursuant to this article. The provisions of this article may not apply to an entity properly licensed by a reciprocal state to provide health care services to employer groups, where residents of West Virginia are members of an employer group, and the employer group contract is entered into in the reciprocal state. For purposes of this subsection, a "reciprocal state" means a state which physically borders West Virginia and which has subscriber or enrollee hold harmless requirements substantially similar to those set out in section seven-a of this article.

(b) Factually accurate advertising or solicitation regarding the range of services provided, the premiums and copayments charged, the sites of services and hours of operation and any other quantifiable, nonprofessional aspects of its operation by a health maintenance organization granted a certificate of authority or its representative may not be construed to violate any provision of law relating to solicitation or advertising by health professions: Provided, That nothing contained in this subsection shall be construed as authorizing any solicitation or advertising which identifies or refers to any individual provider or makes any qualitative judgment concerning any provider.

(c) Any health maintenance organization authorized under this article may not be considered to be practicing medicine and is exempt from the provisions of chapter thirty of this code relating to the practice of medicine.

(d) The following provisions of this chapter are applicable to any health maintenance organization granted a certificate of authority under this article or which is otherwise subject to the provisions of this article: The provisions of sections four, five, six, seven, eight, nine and nine-a, article two (Insurance Commissioner); sections fifteen and twenty, article four (general provisions); section twenty, article five (borrowing by insurers); section seventeen, article six (validity of noncomplying forms); article six-c (guaranteed loss ratios as applied to individual sickness and accident insurance policies); article seven (assets and liabilities); article eight (investments); article eight-a (use of clearing corporations and federal reserve book-entry system); article nine (administration of deposits); article ten (rehabilitation and liquidation); article twelve (insurance producers and solicitors); section fourteen, article fifteen (policies discriminating among health care providers); section sixteen, article fifteen (policies not to exclude insured's children from coverage; required services; coordination with other insurance); section eighteen, article fifteen (equal treatment of state agency); section nineteen, article fifteen (coordination of benefits with Medicaid); article fifteen-b (Uniform Health Care Administration Act); section three, article sixteen (required policy provisions); section three-f, article sixteen (required policy

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provisions - treatment of temporomandibular joint disorder and craniomandibular disorder); section eleven, article sixteen (group policies not to exclude insured's children from coverage; required services; coordination with other insurance); section thirteen, article sixteen (equal treatment of state agency); section fourteen, article sixteen (coordination of benefits with Medicaid); article sixteen-a (group health insurance conversion); article sixteen-d (marketing and rate practices for small employer accident and sickness insurance policies); article twenty-five-c (Health Maintenance Organization Patient Bill of Rights); article twenty-five-f (coverage for patient cost of clinical trials); article twenty-seven (insurance holding company systems); article thirty-three (annual audited financial report); article thirty-four (administrative supervision); article thirty-four-a (standards and commissioner's authority for companies considered to be in hazardous financial condition); article thirty-five (criminal sanctions for failure to report impairment); article thirty-seven (managing general agents); article thirty-nine (disclosure of material transactions); article forty-a (risk-based capital for health organizations); article forty-one (Insurance Fraud Prevention Act); and article forty-two (Women's Access to Health Care Act). In circumstances where the code provisions made applicable to health maintenance organizations by this subsection refer to the insurer, the corporation or words of similar import, the language shall be construed to include health maintenance organizations.

(e) Any long-term care insurance policy delivered or issued for delivery in this state by a health maintenance organization shall comply with the provisions of article fifteen-a of this chapter.

WV Legislature

§33-25A-24a.

Repealed.

Acts, 2005 Reg. Sess., Ch. 143.

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§33-25A-24b.

Repealed.

Acts, 2005 Reg. Sess., Ch. 143.

WV Legislature

§33-25A-25. Filings and reports as public documents.

All applications, filings and reports required under this article shall be treated as public documents: Provided, That where the provisions of other articles in this chapter are applicable to health maintenance organizations, all applications, filings and reports required under those articles shall be afforded the level of confidentiality as provided in those articles.

WV Legislature

§33-25A-26. Confidentiality of medical information.

Any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant obtained from that person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except: (1) To the extent that it may be necessary to facilitate an assessment of the quality of care delivered pursuant to section seventeen of this article or to review the grievance procedure pursuant to section twelve of this article; (2) upon the express written consent of the enrollee or his or her legally authorized representative; (3) pursuant to statute or court order for the production of evidence or the discovery thereof; (4) in the event of claim or litigation between that person and the health maintenance organization wherein the data or information is pertinent; or (5) to a department or division of the state pursuant to the terms of a group contract for the provision of health care services between the HMO and the department or division of the state. A health maintenance organization is entitled to claim any statutory privileges against the disclosure which the provider who furnished the information to the health maintenance organization is entitled to claim.

WV Legislature

§33-25A-27. Authority to contract with health maintenance organizations under Medicaid.

The Department of Human Services may to enter into contracts with health maintenance organizations certified and permitted to market under the laws of this state, and to furnish to recipients of medical assistance under Title XIX of the Social Security Act, 42 U.S.C. Section 1396, *et. seq.*, health care services offered to such recipients under the medical assistance plan of West Virginia.

WV Legislature

§33-25A-28. Required health maintenance organization option.

(1) Each employer shall offer no less than once every year to every employee and dependent entitled to receive health care under an existing health benefit plan supported in whole or in part by such employer the opportunity to become enrollees in certified health maintenance organizations which have the capacity to provide basic health services in health maintenance organization service areas in which at least twenty-five such employees reside: Provided, That nothing herein shall require an employer to contribute more on behalf of an employee seeking to enroll in a health maintenance organization than would be contributed on the employee's behalf to the existing health plan.

(2) If any employees of an employer are represented by a collective bargaining representative or other employee representative designated or selected under any law of this state, the offer described in subsection (1) of this section should be made to such collective bargaining representatives or other employee representative, and only if such representative approves the offer should it be made to employees represented by such representatives.

(3) If there is more than one certified health maintenance organization which meets the requirements of subsection (1) of this section and such health maintenance organizations have service areas contemporaneously covering the same twenty-five or more employees, the employer shall offer such employees at least one health maintenance organization which provides health services primarily through staff physicians, or medical groups, or a combination of both; and one health maintenance organization which provides health services through other means.

(4) Any employer who knowingly fails to comply with any of the requirements of this section shall be subject to a fine of not more than $10,000 for every thirty-day period that such violation continues.

(5) The commissioner is authorized, in addition to the remedy provided in subsection (4) of this section, to seek an injunction in a court of competent jurisdiction to compel compliance with the provisions of this section.

WV Legislature

§33-25A-29.

Repealed.

Acts, 2005 Reg. Sess., Ch. 143.

WV Legislature

§33-25A-30.

Repealed.

Acts, 2005 Reg. Sess., Ch. 143.

WV Legislature

§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 policy, plan or contract shall be construed to include payment to all health care providers including medical physicians, osteopathic physicians, podiatric physicians, chiropractic physicians, midwives and nurse practitioners 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.

WV Legislature

§33-25A-32. Authority of commissioner to promulgate rules and regulations regarding affiliate and subsidiary operating results.

The commissioner may as he deems necessary after notice and hearing promulgate rules and regulations in accordance with chapter twenty-nine-a of this code to define the commissioner's authority to consider the operating results of an insurer's affiliates and subsidiaries in the rate making and solvency determination of that insurer.

WV Legislature

§33-25A-33. Guaranty fund.

On or before January 15, 1996, the commissioner shall submit a report to the Legislature setting forth a plan to establish a guaranty fund for health maintenance organizations operating in West Virginia.

WV Legislature

§33-25A-34. Ambulance services.

The Legislature finds that ambulance services in this state are performed by various volunteer emergency service squads, county operations and small businesses, which may lack the sophistication and expertise required to negotiate a contract with a health maintenance organization for the provision of ambulance services, and that the best interests of the citizens of the state require the continued development and preservation of an emergency medical system to serve all the citizens of the state, including those citizens who do not receive health care services through a health maintenance organization. Therefore, the commissioner shall promulgate legislative rules, pursuant to the provisions of article twenty-nine-a of this code, to regulate contracting for emergency medical services. The rules shall be promulgated as expeditiously as possible in order to be considered by the Legislature in the regular session in the year one thousand nine hundred ninety-seven. The rules shall consider the following: Reimbursement for nonemergency transportation by nonparticipating providers and the appropriate use of 911 or community dispatching, as well as other items the commissioner may deem necessary.

WV Legislature

§33-25A-35. Rural health maintenance organizations.

[Repealed.]

WV Legislature

§33-25A-36. Assignment of certain benefits in dental care insurance coverage.

(a) Any entity regulated under this article that provides dental care coverage to a covered person shall honor an assignment, made in writing by the person covered under the policy, of payments due under the policy to a dentist or a dental corporation for services provided to the covered person that are covered under the policy. Upon notice of the assignment, the entity shall make payments directly to the provider of the covered services. A dentist or dental corporation with a valid assignment may bill the entity and notify the entity of the assignment. Upon request of the entity, the dentist or dental corporation shall provide a copy of the assignment to the entity.

(b) A covered person may revoke an assignment made pursuant to subsection (a) of this section with or without the consent of the provider. The revocation shall be in writing. The covered person shall provide notice of the revocation to the entity. The entity shall send a copy of the revocation notice to the dentist or dental corporation subject to the assignment. The revocation is effective when both the entity and the provider have received a copy of the revocation notice. The revocation is only effective for any charges incurred after both parties have received the revocation notice.

(c) If, under an assignment authorized in subsection (a) of this section, a dentist or dental corporation collects payment from a covered person and subsequently receives payment from the entity, the dentist or dental corporation shall reimburse the covered person, less any applicable copayments, deductibles, or coinsurance amounts, within 45 days.

(d) Nothing in this section limits an entity’s ability to determine the scope of the entity’s benefits, services, or any other terms of the entity’s policies or to negotiate any contract with a licensed health care provider regarding reimbursement rates or any other lawful provisions.

(e) Any entity providing dental care shall provide conspicuous notice to the covered person that the assignment of benefits is optional, and that additional payments may be required if the assigned benefits are not sufficient to pay for received services.

(f) The provisions of this section shall not apply to insurers or managed care organizations with respect to their Medicaid or CHIP plans or contracts which are reviewed and approved by the Bureau for Medical Services.

WV Legislature

§33-25A-37. Required coverage for scalp cooling system for cancer chemotherapy treatment.

(a) For the purpose of this section, "scalp cooling system" means any device used to cool the human scalp to prevent or reduce hair loss during cancer chemotherapy treatment, provided that such device is designed and intended for repeated use and is primarily and customarily used to serve a medical purpose.

(b) Any insurer who delivers or issues a policy, plan, or contact that is issued or renewed on or after January 1, 2027, under the provisions of this article and provides coverage for cancer chemotherapy treatment shall provide coverage for scalp cooling systems used in connection with cancer chemotherapy treatment as defined by the Centers for Medicare and Medicaid Services. Coverage provided under this section may be subject to annual deductibles and coinsurance, including copayments, as may be deemed appropriate by the commissioner and as are consistent with those established for other benefits within a given policy.

WV Legislature

§33-25A-38. Prohibiting surprise billing of ground emergency medical services by non-participating providers.

(a) For a health insurance policy issued by an insurer on or after January 1, 2027:

(1) Payment by an insurer to a non-participating emergency medical services agency for covered ambulance services provided under the provisions of §16-4C-1 *et seq*. of this code, excluding air ambulance services as defined in §16-4C-3(a) of this code, to a covered enrollee in accordance with subdivision (2) of this subsection:

(A) Shall be considered payment in full for the ambulance services provided, except for any copayment, coinsurance, deductible, and other cost-sharing amounts that the insurer requires the covered enrollee to pay; and

(B) The non-participating emergency medical services agency is prohibited from billing the covered individual for any additional amount for the ambulance services provided, except for any copayment, coinsurance, deductible, and other cost-sharing amounts that the insurer requires the covered enrollee to pay.

(2) The insurer shall provide direct payment to a non-participating emergency medical services agency for covered ground ambulance services provided to a covered individual:

(A) At the rate of 200 percent of the current published rate for ambulance services as established by the Centers for Medicare and Medicaid Services under Title XVIII of the federal Social Security Act, 42 U.S.C. 1395 *et seq*., for the same ambulance services provided in the same geographic area; or

(B) According to the non-participating emergency medical service agency's billed charges; whichever is less.

(3) The copayment, coinsurance, deductible, and other cost-sharing amounts that an insurer requires a covered individual to pay in connection with ground ambulance services provided to the covered individual by a non-participating emergency medical services agency shall not exceed the copayment, coinsurance, deductible, and other cost-sharing amounts that the covered individual would be required to pay if the ambulance services had been provided to the covered individual by a participating emergency medical services agency.

(4) If an insurer receives a clean claim for ground ambulance services provided to a covered individual by a non-participating emergency medical services agency, the insurer shall remit payment for the ambulance services directly to the non-participating emergency medical services agency not more than 30 days after receiving a clean claim and shall not send payment to the covered individual.

(5) An insurer shall either pay or deny a clean claim for ground ambulance services provided to a covered individual by a non-participating emergency medical services agency within 30 days of receipt of the claim, except in the following circumstances:

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(A) Another payor or party is responsible for the claim;

(B) The insurer is coordinating benefits with another payor;

(C) The provider has already been paid for the claim;

(D) The claim was submitted fraudulently; or

(E) There was a material misrepresentation in the claim.

(6) If an insurer denies a claim for ground ambulance services provided to a covered individual by a non-participating emergency medical services agency, the insurer shall provide written notice that:

(A) Acknowledges the date of the receipt of the claim; and

(B) States that the insurer is declining to pay all or part of the claim and sets forth the specific reason or reasons for declining to pay the claim in full; or

(C) States that additional information is needed to determine whether all or part of the claim is payable and specifically describes the additional information that is needed.

(b) This section shall not apply to insurers that have a contract with the Bureau for Medical Services relating to Medicaid or CHIP.

WV Legislature