WEST VIRGINIA CODE CHAPTER 33 ARTICLE 25C

WV Legislature

§33-25C-1. Short title and purpose.

This article may be referred to as the "Patients' Bill of Rights." It is the intent of the Legislature that enrollees covered by health care plans receive quality, cost-effective health care designed to maintain and improve their health. The purpose of this article is to ensure that health plan enrollees:

(a) Have improved access to information regarding their health plans;

(b) Have sufficient and timely access to appropriate health care services, and choice among health care providers;

(c) Are assured that health care decisions are made by appropriate medical personnel;

(d) Have access to a quick and impartial process for appealing plan decisions;

(e) Are protected from unnecessary invasions of health care privacy; and

(f) Are assured that personal health care information will be used only as necessary to obtain and pay for health care or to improve the quality of care.

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§33-25C-2. Definitions.

For purposes of this article:

(a) "Commissioner" means the commissioner of insurance.

(b) "Credentials" means medical training, education, specialties, and board certifications of the provider.

(c) "Enrollee" is a natural person who has entered into an agreement with a health maintenance organization or prepaid limited health service organization for the provision of managed health care.

(d) "External review" means a process, independent of all affected parties, to determine if a health care service is medically necessary, or experimental.

(e) "Health care plan" means a plan that establishes, operates, or maintains a network of health care providers that have entered into agreements with the plan to provide health care services to enrollees to whom the plan has the ultimate obligation to arrange for the provision of or payment for services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution.

For purposes of this definition, "health care plan" shall not include indemnity health insurance policies including those using a contracted provider network;

(f) "Managed care plan" or "plan" means any health maintenance organization or prepaid limited health service organization: Provided, That this article only applies to prepaid limited health service organizations to the extent of coverage and services these organizations offer;

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

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§33-25C-3. Notice of certain enrollee rights.

All managed care plans must on or after July 1, 2002, provide to enrollees a notice of certain enrollee rights. The notice shall be provided to enrollees on a yearly basis on a form prescribed by the commissioner and shall include, but not be limited to:

(a) The enrollee's rights to a description of his or her rights and responsibilities, plan benefits, benefit limitations, premiums, and individual cost-sharing requirements;

(b) The enrollee's right to a description of the plan's grievance procedure and the right to pursue grievance and hearing procedures without reprisal from the managed care plan;

(c) A description of the method in which an enrollee can obtain a listing of the plan's provider network, including the names and credentials of all participating providers, and the method in which an enrollee may choose providers within the plan;

(d) The enrollee's right to privacy and confidentiality;

(e) The right to full disclosure from the enrollee's health care provider of any information relating to his or her medical condition or treatment plan, and the ability to examine and offer corrections to the enrollee's medical records;

(f) The enrollee's right to be informed of plan policies and any charges for which the enrollee will be responsible;

(g) The right of enrollees to have coverage denials involving medical necessity or experimental treatment reviewed by appropriate medical professionals who are knowledgeable about the recommended or requested health service, as part of an external review as provided in this article;

(h) A description of the method in which an enrollee can obtain access to a summary of the plan's accreditation report;

(i) The right of an enrollee to have medical advice or options communicated to him or her without any limitations or restrictions being placed upon the provider or primary care physician by the managed care plan;

(j) A list of all other legally mandated benefits to which the enrollee is entitled, including coverage for services provided pursuant to sections eight-a, eight-b, eight-c, eight-d, eight-e, article twenty-five-a of this chapter, article twenty-five-e of this chapter, and article forty-two of this chapter, and all rules promulgated pursuant to this chapter regulating managed care plans.

(k) Any other areas the commissioner may propose in accordance with section nine of this article.

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§33-25C-4. Access to appropriate health services.

(a) Each managed care plan must allow an enrollee to choose a primary care provider who is accepting new enrollees from a list of participating providers. Enrollees also must be permitted to change primary care providers after six months with the change becoming effective no later than the beginning of the month next following the enrollee's request for the change.

(b) The enrollee's managed care plan may not provide to any provider or any primary care physician an incentive or disincentive plan that includes specific payment made directly or indirectly, in any form, to the provider or primary care physician as an inducement to deny, release, limit, or delay specific, medically necessary and appropriate services provided with respect to a specific enrollee or groups of enrollees with similar medical conditions.

(c) A managed care plan shall have a procedure by which an enrollee, upon diagnosis with a life-threatening, degenerative or disabling condition or disease, either of which requires specialized health care over a prolonged period of time, may receive a standing referral to a specialist with expertise in that condition or disease who will be responsible for and capable of providing and coordinating the member's specialty care. When a standing referral is made, the managed care plan shall periodically review the referral for continued necessity.

(d) Each managed care plan must provide for appropriate and timely referral of enrollees to a choice of specialists within the plan if specialty care is warranted. The referral shall be first to a specialist located in the geographic area of the plan in which the enrollee resides and if an appropriate specialist is not available in the area, then to a specialist located elsewhere within the plan. If the type of medical specialist who is appropriate for a specific condition is not represented on the specialty panel, enrollees must have access to nonparticipating specialty health care providers in a manner consistent with their managed care contract.

(e) Each managed care plan must, upon the request of an enrollee, provide access by the enrollee to a second opinion regarding a diagnosis or treatment plan requiring a serious or complex procedure, from a qualified participating provider.

(f) Each managed care plan must, at the option of the enrollee, continue to cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract for at least sixty days following notice of termination to the enrollees. The plan's obligation to continue to cover the primary care physician's services is contingent upon the primary care physician's acceptance and compliance with the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the managed care plan assign new enrollees to the terminated provider.

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§33-25C-5.

Repealed.

Acts, 2013 Reg. Sess., Ch. 107.

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§33-25C-6.

Repealed.

Acts, 2013 Reg. Sess., Ch. 107.

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§33-25C-7.

Repealed.

Acts, 2013 Reg. Sess., Ch. 107.

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§33-25C-8. Delegation of duties.

Each managed care plan is accountable for and must oversee any activities required by this article that it delegates to any subcontractor. No contract with a subcontractor executed by the managed care plan or the subcontractor may relieve the managed care plan of its obligations to any enrollee for the provision of health care services or of its responsibility for compliance with statutes or rules.

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§33-25C-9.

Repealed.

Acts, 2013 Reg. Sess., Ch. 107.

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§33-25C-10. Construction.

To the extent permitted by law, if any provision of this article conflict with other state or federal law, then the provision must be construed in a manner most favorable to the enrollee.

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§33-25C-11.

Repealed.

Acts, 2013 Reg. Sess., Ch. 107.

WV Legislature