WEST VIRGINIA CODE CHAPTER 33 ARTICLE 55

WV Legislature

§33-55-1. Definitions.

For purposes of this article:

"Authorized representative" means:

(A) A person to whom a covered person has given express written consent to represent the covered person;

(B) A person authorized by law to provide substituted consent for a covered person; or

(C) The covered person’s treating health care professional, only when the covered person is unable to provide consent, or a family member of the covered person.

"Commissioner" means the Insurance Commissioner of this state.

"Covered benefit" or "benefit" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

"Emergency medical condition" means a physical, mental, or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect, in the absence of immediate medical attention, to result in:

(A) Placing the individual’s physical, mental, or behavioral health, or, with respect to a pregnant woman, the woman’s or her fetus’s health in serious jeopardy;

(B) Serious impairment to a bodily function;

(C) Serious impairment of any bodily organ or part; or

(D) With respect to a pregnant woman who is having contractions:

(i) Inadequate time to affect a safe transfer to another hospital before delivery; or

(ii) When transfer to another hospital may pose a threat to the health or safety of the woman or fetus.

"Emergency services" means, with respect to an emergency condition:

(A) A medical or mental health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

WV Legislature

(B) Any further medical or mental health examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

"Essential community provider" or "ECP" means a provider that:

(A) Serves predominantly low-income, medically underserved individuals, including a health care provider defined in Section 340B(a)(4) of the Public Health Service Act (PHSA); or

(B) Is described in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as set forth by Section 221 of Pub.L.111-8.

"Facility" means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, urgent care centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

"Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified (physical, mental, or behavioral) health care services consistent with their scope of practice under state law.

"Health care provider" or "provider" means a health care professional, a pharmacy, or a facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a physical, mental, or behavioral health condition, illness, injury, or disease, including mental health and substance use disorders.

"Health carrier" or "carrier" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurer issuing an accident and sickness insurance policy pursuant to §33-15-1 *et seq*. of this code, an insurer issuing an accident and sickness group policy pursuant to §33-16-1 *et seq*. of this code, a hospital medical and dental corporation licensed pursuant to §33-24-1 *et seq*. of this code, a health care corporation licensed pursuant to §33-25-1 *et seq*. of this code, or a health maintenance organization licensed pursuant to §33-25A-1 *et seq*. of this code. For purposes of this article, the term "health carrier" or "carrier" does not include insurers or managed care organizations with respect to their Medicaid or Children’s Health Insurance Program (CHIP) plans or contracts which are reviewed and approved by the Bureau for Medical Services.

WV Legislature

"Intermediary" means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

"Limited scope dental plan" means a plan that provides coverage, substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate, or contract of insurance or is otherwise not an integral part of a group benefit plan.

"Limited scope vision plan" means a plan that provides coverage, substantially all of which is for treatment of the eye, that is provided under a separate policy, certificate, or contract of insurance or is otherwise not an integral part of a group benefit plan.

"Network" means the group or groups of participating providers providing services under a network plan.

"Network plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

"Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

"Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

"Primary care" means health care services for a range of common physical, mental, or behavioral health conditions provided by a physician or nonphysician primary care professional.

"Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

"Specialist" means a physician or non-physician health care professional who:

(A) Focuses on a specific area of physical, mental, or behavioral health or a group of patients; and

(B) Has successfully completed required training and is recognized by the state in which he or she practices to provide specialty care.

"Specialist" includes a subspecialist who has additional training and recognition above and

WV Legislature

beyond his or her specialty training.

"Specialty care" means advanced medically necessary care and treatment of specific physical, mental, or behavioral health conditions, or those health conditions which may manifest in particular ages or subpopulations, that are provided by a specialist, preferably in coordination with a primary care professional or other health care professional.

"Telemedicine" or "Telehealth" means health care services provided through telecommunications technology by a health care professional who is at a location other than where the covered person is located.

"Tiered network" means a network that identifies and groups some or all types of providers and facilities into specific groups to which different provider reimbursement, covered person cost-sharing, or provider access requirements, or any combination thereof, apply for the same services.

"To stabilize" means with respect to an emergency medical condition to provide such medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual to or from a facility, or, with respect to an emergency birth with no complications resulting in a continued emergency to deliver the child and the placenta.

"Transfer" means the movement, including the discharge, of an individual outside a hospital’s facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who:

(A) Has been declared dead; or

(B) Leaves the facility without the permission of any such person.

WV Legislature

§33-55-2. Applicability and scope.

(a) Except as provided in subsection (b) of this section, this article applies to all health carriers that offer network plans.

(b) The following provisions of this article do not apply to health carriers that offer network plans that consist solely of limited scope dental plans or limited scope vision plans:

(1) §33-55-3(a)(2) of this code;

(2) §33-55-3(f)(7)(E), §33-55-3(f)(8)(B) and §33-55-3(f)(11) of this code;

(3) §33-55-4(b)(2) and (3) of this code; and

(4) §33-55-4(c)(1)(A) and (B), §33-55-4(c)(2), §33-55-4(c)(3), §33-55-4(d)(1)(B) and §33-55-4(d)(1)(C) of this code.

WV Legislature

§33-55-3. Network adequacy.

(a)(1) A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.

(2) Covered persons have access to emergency services 24 hours per day, seven days per week.

(b) The commissioner shall determine sufficiency in accordance with the requirements of this section, and may establish sufficiency by reference to any reasonable criteria, which may include, but are not limited to:

(1) Provider-covered person ratios by specialty;

(2) Primary care professional-covered person ratios;

(3) Geographic accessibility of providers;

(4) Geographic variation and population dispersion;

(5) Waiting times for an appointment with participating providers;

(6) Hours of operation;

(7) The ability of the network to meet the needs of covered persons, which may include low-income persons, children and adults with serious, chronic, or complex health conditions or physical or mental disabilities, or persons with limited English proficiency;

(8) Other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence, and other ways of delivering care; and

(9) The volume of technological and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services.

(c)(1) A health carrier shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a nonparticipating provider, or make other arrangements acceptable to the commissioner when:

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

WV Legislature

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

(2) The health carrier shall specify and inform covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider as provided in subdivision (1) of this subsection when:

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

(B) The health carrier:

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

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

(3) The health carrier shall treat the health care services the covered person receives from a nonparticipating provider pursuant to subdivision (2) of this subsection as if the services were provided by a participating provider, including counting the covered person's cost-sharing for such services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.

(4) The process described under subdivisions (1) and (2) of this subsection shall ensure that requests to obtain a covered benefit from a nonparticipating provider are addressed in a timely fashion appropriate to the covered person's condition.

(5) The health carrier shall have a system in place that documents all requests to obtain a covered benefit from a nonparticipating provider under this subsection and shall provide this information to the commissioner upon request.

(6) The process established in this subsection is not intended to be used by health carriers as a substitute for establishing and maintaining a sufficient provider network in accordance with the provisions of this article nor is it intended to be used by covered persons to circumvent the use of covered benefits available through a health carrier's network delivery system options.

(7) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.

(d)(1) A health carrier shall establish and maintain adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business address. In determining whether the health carrier has complied with this

WV Legislature

provision, the commissioner shall give due consideration to the relative availability of health care providers with the requisite expertise and training in the service area under consideration.

(2) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its participating providers to furnish all contracted covered benefits to covered persons.

(e)(1) Beginning January 1, 2021, a health carrier shall file with the commissioner for review prior to or at the time it files a newly offered network, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this article.

(2)(A) The health carrier may request the commissioner to deem sections of the access plan as proprietary information that may not be made public. The health carrier shall make the access plans, absent proprietary information, available online, at its business premises, and to any person upon request.

(B) For the purposes of this subsection, information is proprietary if revealing the information would cause the health carrier's competitors to obtain valuable business information.

(3) The health carrier shall prepare an access plan prior to offering a new network plan and shall notify the commissioner of any material change to any existing network plan within 15 business days after the change occurs. The carrier shall include in the notice to the commissioner a reasonable timeframe within which it will submit to the commissioner for approval or file with the commissioner, as appropriate, an update to an existing access plan.

(f) The access plan shall describe or contain at least the following:

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

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

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

(4) The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select providers;

(5) The health carrier's efforts to address the needs of covered persons, including, but not limited to, children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic, or complex medical conditions. This includes the carrier's efforts, when appropriate, to

WV Legislature

include various types of ECPs in its network;

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

(7) The health carrier's method of informing covered persons of the plan's covered services and features, including, but not limited to:

(A) The plan's grievance and appeals procedures;

(B) Its process for choosing and changing providers;

(C) Its process for updating its provider directories for each of its network plans;

(D) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and

(E) Its procedures for covering and approving emergency, urgent, and specialty care, if applicable;

(8) The health carrier's system for ensuring the coordination and continuity of care:

(A) For covered persons referred to specialty physicians; and

(B) For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(9) The health carrier's process for enabling covered persons to change primary care professionals, if applicable;

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

(11) The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care, and pathology/laboratory services at their participating hospitals; and

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

WV Legislature

§33-55-4. Provider directories.

(a)(1)(A) A health carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search functions, as described in subsection (b) of this section.

(B) In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2)(A) The health carrier shall update each network plan provider directory at least monthly.

(B) The health carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy, and retain documentation of such an audit to be made available to the commissioner upon request.

(3) A health carrier shall provide a print copy, or a print copy of the requested directory information of a current provider directory with the information described in subsection (b) of this section upon request of a covered person or a prospective covered person.

(4) For each network plan, a health carrier shall include in plain language, in both the electronic and print directory, the following general information:

(A) In plain language, a description of the criteria the carrier has used to build its provider network;

(B) If applicable, in plain language, a description of the criteria the carrier has used to tier providers;

(C) If applicable, in plain language, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital, or other type of facility in the network which tier each is placed, for example, by name, symbols, or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier; and

(D) If applicable, note that authorization or referral may be required to access some providers.

(5)(A) A health carrier shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state.

(B) The health carrier shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.

WV Legislature

(6) For the pieces of information required pursuant to subsections (b), (c), and (d) of this section in a provider directory pertaining to a health care professional, a hospital, or a facility other than a hospital, the health carrier shall make available through the directory the source of the information and any limitations, if applicable.

(7) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

(b) The health carrier shall make available through an electronic provider directory, for each network plan, the information under this subsection in a searchable format:

(1) For health care professionals:

(A) Name;

(B) Gender;

(C) Participating office location(s);

(D) Specialty, if applicable;

(E) Medical group affiliations, if applicable;

(F) Facility affiliations, if applicable;

(G) Participating facility affiliations, if applicable;

(H) Languages spoken other than English, if applicable; and

(I) Whether accepting new patients.

(2) For hospitals:

(A) Hospital name;

(B) Hospital type (i. e., acute, rehabilitation, children’s, cancer);

(C) Participating hospital location;

(D) Hospital accreditation status; and

(3) For facilities, other than hospitals, by type:

(A) Facility name;

(B) Facility type;

WV Legislature

(C) Types of services performed; and

(D) Participating facility location(s).

(c) For the electronic provider directories, for each network plan, a health carrier shall make available the following information in addition to all of the information available under subsection (b) of this section:

(1) For health care professionals:

(A) Contact information;

(B) Board certification(s); and

(C) Languages spoken other than English by clinical staff, if applicable.

(2) For hospitals: Telephone number; and

(3) For facilities other than hospitals: Telephone number.

(d)(1) The health carrier shall make available in print, upon request, the following provider directory information for the applicable network plan:

(A) For health care professionals:

(i) Name;

(ii) Contact information;

(iii) Participating office location(s);

(iv) Specialty, if applicable;

(v) Languages spoken other than English, if applicable; and

(vi) Whether accepting new patients.

(B) For hospitals:

(i) Hospital name;

(ii) Hospital type, (i. e., acute, rehabilitation, children’s, cancer); and

(iii) Participating hospital location and telephone number; and

(C) For facilities, other than hospitals, by type:

WV Legislature

(i) Facility name;

(ii) Facility type;

(iii) Types of services performed; and

(iv) Participating facility location(s) and telephone number.

(2) The health carrier shall include a disclosure in the directory that the information in subdivision (1) of this subsection, included in the directory, is accurate as of the date of printing, and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website to obtain current provider directory information.

WV Legislature

§33-55-5. Intermediaries.

A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this section.

(a) A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons may not be delegated or assigned to the intermediary.

(b) A health carrier has the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

(c) A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon 20 days prior written notice from the health carrier.

(d) If applicable, an intermediary shall transmit utilization documentation and claims-paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.

(e) If applicable, an intermediary shall maintain the books, records, financial information, and documentation of services provided to covered persons at its principal place of business in the state and preserve them for two years in a manner that facilitates regulatory review.

(f) An intermediary shall allow the commissioner access to the intermediary's books, records, financial information, and any documentation of services provided to covered persons, as necessary to determine compliance with this article.

(g) A health carrier has the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services. If a health carrier requires assignment, the health carrier remains obligated to pay the provider for furnishing covered services under the same terms and conditions as the intermediary prior to the insolvency.

(h) Notwithstanding any other provision of this section, to the extent the health carrier delegates its responsibilities to the intermediary, the carrier shall retain full responsibility for the intermediary's compliance with the requirements of this article.

WV Legislature

§33-55-6. Filing requirements and state administration.

(a) At the time a health carrier files its access plan, the health carrier shall file for approval with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.

(b) A health carrier shall submit material changes to a contract that would affect a provision required under this article or implementing regulations to the commissioner for approval at least 30 days prior to use.

(c) The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon 20 days prior written notice from the commissioner.

WV Legislature

§33-55-7. Contracting.

(a) The execution of a contract by a health carrier does not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.

(b) All contracts shall be in writing and subject to review.

(c) All contracts shall comply with applicable requirements of the law and applicable regulations.

WV Legislature

§33-55-8. Enforcement.

(a) If the commissioner determines that a health carrier has not contracted with a sufficient number of participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier's network access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this article, or that a health carrier has not complied with a provision of this article, the commissioner shall require a modification to the access plan or institute a corrective action plan, as appropriate, that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this article.

(b) The commissioner will not act to arbitrate, mediate, or settle disputes regarding a decision not to include a provider in a network plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries, or one or more providers arising under or by reason of a provider contract or its termination.

WV Legislature

§33-55-9. Rulemaking.

The commissioner shall propose a rule for legislative approval in accordance with the provisions of §29A-3-1 et seq. of this code to implement the provisions of this article.

WV Legislature

§33-55-10. Penalties.

A violation of this article shall be penalized in accordance with §33-4-11 of this code.

WV Legislature