H.B. 2216

WEST VIRGINIA LEGISLATURE

FIRST REGULAR SESSION, 2001

ENROLLED

COMMITTEE SUBSTITUTE
FOR
House Bill No. 2216

(By Mr. Speaker, Mr. Kiss, and Delegate Trump)
[By Request of the Executive]

Passed April 14, 2001

In Effect Ninety Days from Passage

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[BY REQUEST OF THE EXECUTIVE]

[Passed April 14, 2001; in effect ninety days from passage.]

AN ACT to amend and reenact sections one, two and three, article twenty-five-c, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended; and to further amend said article by adding thereto eight new sections, designated sections four through eleven, all relating to managed care plan's benefits and responsibilities; amending statement of purpose for patients bill of rights; amending definitions; providing for notice of certain enrollee rights; prohibiting incentives or disincentives to providing care; allowing standing referrals; requiring internal grievance procedures; establishing the right to an external review of coverage denials; requiring certain enrollee benefits and services; establishing appeal process and requirements; establishing standards for external review and external review organizations; authorizing insurance commissioner to promulgate rules; providing civil liability for failure of managed

care plan to comply with external review decisions; creating internal effective date; and providing rules of construction of this act.

Be it enacted by the Legislature of West Virginia:

That sections one, two and three, article twenty-five-c, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted; and that said article be further amended by adding thereto eight new sections, designated sections four through eleven, all to read as follows:

ARTICLE 25C. HEALTH MAINTENANCE ORGANIZATION PATIENT BILL OF RIGHTS.

§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 act 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.

§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.

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

All managed care plans must on or after the first day of July, two thousand and two 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.

§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.

§33-25C-5. Enrollee complaints; internal grievance procedure.

(a) Each managed care plan must establish and maintain an internal grievance procedure for the fair consideration of disputes relating to any provisions of the plan's contract, 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; the quality of health care services; or decisions by managed care plans to deny, modify, reduce, or terminate coverage of or payment for health care services for an enrollee, as more specifically set forth in section twelve, article twenty-five-a, chapter thirty-three of this code.

(b) Except for determinations of whether a health care service is medically necessary, or determinations of whether a health care service is experimental, an enrollee may appeal the final decision resulting from the internal grievance procedure to the insurance commissioner, as set forth in section twelve, article twenty-five-a, chapter thirty-three of this code.

(c) Any party aggrieved by an order of the insurance commissioner may appeal to the circuit court of Kanawha

county, as set forth in section fourteen, article two, chapter thirty-three. The judgment of the circuit court may be reviewed upon appeal by the supreme court of appeals in the same manner as other civil cases to which the State is a party.

§33-25C-6. External review of health care disputes.

(a) For determinations of whether a health care service is medically necessary, or determinations of whether a health care service is experimental, an enrollee may seek review by a certified external review organization of a managed care plan's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service, after exhausting the managed care plan's internal grievance process and receiving a decision that is unfavorable to the enrollee, or after the managed care plan has exceeded the time periods for grievances provided in section twelve, article twenty-five-a of this chapter, without good cause and without reaching a decision.

(b) A request for external review must be made in writing to the managed care plan and the insurance commissioner, within sixty days after the managed care plan has exceeded the time periods for grievances without reaching a decision, as set forth in subsection a of this section, or within sixty days after receiving an unfavorable decision by the managed care plan.

(c) External reviews may be requested by enrollees where the denial, reduction, modification or termination of payment for health care services for an enrollee would result in payment of at least one thousand dollars or a course of health care services that would exceed one thousand dollars by the enrollee if the health care were paid for by the enrollee.

(d) In an external review, the external review organization must consider, at a minimum, the information submitted by the managed care plan, the enrollee and the enrollee's provider, including the enrollee's medical records; the terms and condi-

tions of the plan; and the standards, criteria and clinical rationale used by the managed care plan to reach its decision.

(e) External reviews relate only to questions of whether a health care service is medically necessary or whether a health care service is experimental. The cost of external reviews shall be borne by the managed care plan.

(f) Determinations of whether a health care service is medically necessary will be made by an external review organization through use of at least one physician, or other provider appropriate to the health care service under consideration, who is knowledgeable about the recommended or requested health service.

(g) Determinations of whether a health care service is experimental will be made by an external review organization through use of a panel of at least three physicians, or other providers appropriate to the health care service under consideration, who are knowledgeable about the recommended or requested health service.

(h) External reviews which relate to both a determination of whether a health care service is medically necessary and a determination of whether a health care service is experimental will be conducted by a panel of at least three physicians, or other providers appropriate to the health care service under consideration, who are knowledgeable about the recommended or requested health service.

(i) Questions of coverage of health care services which do not include determinations of whether a health care service is medically necessary or whether a health care service is experimental will be confined to the internal grievance procedure as referenced in section five of this article and set forth in section twelve, article twenty-five-a of this chapter, and in the rules of the insurance commissioner.

(j) Failure of the managed care plan to make all reasonable efforts to provide medical and other relevant records to the external review organization within the time frames set by the commissioner will result in a determination in the external review adverse to the managed care plan, in which event the managed care plan must provide coverage for the requested or proposed health care services.

(k) Failure of the enrollee to provide medical and other relevant records to the external review organization within the time frames established by the commissioner will result in the external review proceeding to decision without consideration of the records in the possession or control of the enrollee.

(*l*) Upon written request, the commissioner may grant additional time, for good cause shown, in which a party may forward records to the external review organization if the party has made a timely request to the provider to forward the records, and the provider has failed to forward the records as requested. If the external review is an expedited review, the commissioner must consider the possible adverse health consequences to the enrollee in determining whether to permit additional time to comply.

(m) Either the managed care plan or the enrollee may request that the commissioner issue subpoenas to providers for the enrollee's medical or other relevant records.

(n) Upon an enrollee's request, an expedited external review shall be provided within a period of seven days in circumstances where failure of the enrollee to immediately receive the requested or proposed health care service could result in placing the health of the enrollee or the health of enrollee's unborn child in serious jeopardy, cause serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The commissioner may, by rule, shorten the seven day time frame.

(o) The commissioner shall propose rules in accordance with section nine of this article which establish procedures for external reviews under this article and certification of external review organizations. In development of these rules, the commissioner shall consider the latest version of the national association of insurance commissioners health carrier external review model act. These rules shall provide:

(1) The maximum rates and maximum amounts which external review organizations may charge for external reviews;

(2) Procedures for the fair and efficient selection of and assignment of external review organizations to external reviews as they are requested;

(3) Procedures and specific time constraints for the provision of the enrollee's medical and other relevant records to the external review organization upon the occurrence of an external review;

(4) Specified time frames within which the managed care plan and the enrollee must provide all medical and similar records to the external review organization;

(5) Provisions for the confidentiality of enrollee medical records;

(6) Procedures and standards to insure that external review organizations are properly qualified and approved by the commissioner to perform external reviews; and,

(7) Procedures for fair notice to the enrollee and the managed care plan of decisions or other important steps in the external review process.

(p) Upon written application to and approval by the commissioner, a managed care plan may be exempted from the

requirements for external review as specified in this section upon a showing that:

(1) The managed care plan has an established external review procedure in place;

(2) The managed care plan has been reviewed by and maintains a current full accreditation from a nationally recognized accreditation and review organization approved by the commissioner, in accordance with section seventeen-a, article twenty-five-a of this chapter; and

(3) As part of the accreditation process the accreditation and review organization reviewed and approved the managed care plan's external review process.

§33-25C-7. Managed care plan liability.

(a) After settlement or exhaustion of all legal appeals involving determinations of whether health care services are medically necessary or experimental, a managed care plan must comply with the decision rendered in an external review under this article and may be held civilly liable for all damages proximately caused to an enrollee for its failure to so comply.

(b) A managed care plan may not enter into a contract with a physician, hospital, or other health care provider or pharmaceutical company which includes an indemnification or hold harmless clause for the acts or conduct of the managed care plan addressed by this section. Any indemnification of a hold harmless clause in an existing contract is hereby declared void.

(c) It is a defense to any action or liability asserted under this section against a managed care plan that:

(1) The coverage for the health care service in question was provided under the plan and in compliance with the external review decision; or,

(2) Neither the managed care plan, nor any employee, agent, or ostensible agent for the managed care plan controlled, influenced, or participated in the health care decision.

(d) This section does not create any liability on the part of an employer, government agency, or an employer group purchasing organization that purchases coverage or assumes risk on behalf of its employers, or employees, or a governmental agency that purchases coverage on behalf of individuals and families.

(e) A person may not maintain a cause of action under this section against a managed care plan unless:

(1) The affected enrollee or the enrollee's representative has exercised the opportunity established in section five of this article and further established by legislative rule to seek external review of the health care treatment decision;

(2) The determination of the external review association was in favor of the enrollee; and

(3) The managed care plan has not complied with the external review association's decision.

(f) Any action under this section shall be commenced within two years of the completion of the external review process: *Provided,* That a minor or persons under legal disability may commence action within the time period prescribed in section fifteen, article two, chapter fifty-five of this code.

(g) This section does not create any new cause of action, or eliminate any presently existing cause of action.

(h) This section does not apply to workers' compensation insurance under article two, chapter twenty-three of the code.

§33-25C-8. Delegation of duties.

Each managed care plan is accountable for and must oversee any activities required by this act 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.

§33-25C-9. Rules.

The commissioner may propose rules for legislative approval to be effective by the first day of July, two thousand and two and in accordance with the provisions of article three, chapter twenty-nine-a of this code:

(a) To establish further standards for external review procedures to be implemented by managed care plans;

(b) To establish further standards for certification of independent review organizations; and

(c) To further effectuate the purposes of this article.

§33-25C-10. Construction.

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

§33-25C-11. Effective date.

The enrollee's right to an external review by an external review organization certified and selected by the commissioner and the liability provisions contained in subsection (a) of section seven of this article will be effective the first day of July, two thousand two.

That Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

Originating in the House.

In effect ninety days from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker of the House of Delegates

The within is approved this the 30th day of April, 2001.

Governor

PRESENTED TO THE

GOVERNOR

Date 4/24/01

Time 4:35 pm