

H.B. 2216

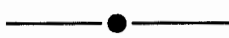
FILED

2001 MAY -1 P 2:19

OFFICE WEST VIRGINIA
SECRETARY OF STATE

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

FILED

2001 MAY -1 P 2:19

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(BY MR. SPEAKER, MR. KISS, AND DELEGATE TRUMP)

[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.

1 This article may be referred to as the “Patients’ Bill of
2 Rights.” It is the intent of the Legislature that enrollees covered
3 by health care plans receive quality, cost-effective health care
4 designed to maintain and improve their health. The purpose of
5 this act is to ensure that health plan enrollees:

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

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

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

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

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

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

§33-25C-2. Definitions.

1 For purposes of this article:

2 (a) “Commissioner” means the commissioner of insurance.

3 (b) “Credentials” means medical training, education,
4 specialties, and board certifications of the provider.

5 (c) “Enrollee” is a natural person who has entered into an
6 agreement with a health maintenance organization or prepaid
7 limited health service organization for the provision of man-
8 aged health care.

9 (d) “External review” means a process, independent of all
10 affected parties, to determine if a health care service is medi-
11 cally necessary, or experimental.

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

20 For purposes of this definition, “health care plan” shall not
21 include indemnity health insurance policies including those
22 using a contracted provider network;

23 (f) “Managed care plan” or “plan” means any health
24 maintenance organization or prepaid limited health service

25 organization: *Provided*, That this article only applies to prepaid
26 limited health service organizations to the extent of coverage
27 and services these organizations offer;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (a) Each managed care plan must establish and maintain an
2 internal grievance procedure for the fair consideration of
3 disputes relating to any provisions of the plan's contract,
4 including but not limited to, claims regarding the scope of
5 coverage for health care services; denials, cancellations or
6 nonrenewals of enrollee coverage; observance of an enrollee's
7 rights as a patient; the quality of health care services; or
8 decisions by managed care plans to deny, modify, reduce, or
9 terminate coverage of or payment for health care services for an
10 enrollee, as more specifically set forth in section twelve, article
11 twenty-five-a, chapter thirty-three of this code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

105 (3) Procedures and specific time constraints for the provi-
106 sion of the enrollee's medical and other relevant records to the
107 external review organization upon the occurrence of an external
108 review;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (d) This section does not create any liability on the part of
22 an employer, government agency, or an employer group
23 purchasing organization that purchases coverage or assumes
24 risk on behalf of its employers, or employees, or a governmen-
25 tal agency that purchases coverage on behalf of individuals and
26 families.

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

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

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

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

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

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

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

§33-25C-8. Delegation of duties.

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

§33-25C-9. Rules.

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

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

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

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

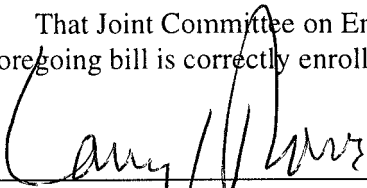
§33-25C-10. Construction.

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

§33-25C-11. Effective date.

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

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



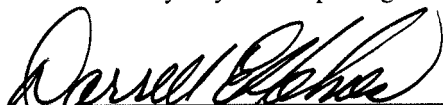
Chairman Senate Committee



Chairman House Committee

Originating in the House.

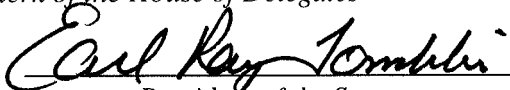
In effect ninety days from passage.



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 4:30 pm