

HB 2960

FILED

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**WEST VIRGINIA LEGISLATURE**  
FIRST REGULAR SESSION, 2013



**ENROLLED**

COMMITTEE SUBSTITUTE  
FOR

**House Bill No. 2960**

(By Delegate(s) Guthrie, Hartman and Manchin)



Passed April 13, 2013

In effect ninety days from passage.

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## H. B. 2960

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(BY DELEGATE(S) GUTHRIE, HARTMAN AND MANCHIN)

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[Passed April 13, 2013; in effect ninety days from passage.]

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**AN ACT to repeal §33-25C-5, §33-25C-6, §33-25C-7, §33-25C-9 and §33-25C-11 of the Code of West Virginia, 1931, as amended; and to amend said code by adding thereto a new article, designated §33-16H-1, §33-16H-2, §33-16H-3 and §33-16H-4, all relating to requiring health plan issuers to develop processes for utilization review, to develop internal grievance procedures, and to make external review available with respect to all adverse determinations; mandating utilization review and internal grievance procedures; providing for external review of adverse determinations; defining terms; providing for judicial review of certain decisions; providing for venue of judicial review; providing for continued benefits pending judicial review; providing for an award of attorneys fees; providing no new causes of action; preserving existing causes of action; repealing similar provisions applicable to only health maintenance organizations; and directing proposal of legislative rules.**

*Be it enacted by the Legislature of West Virginia:*

That §33-25C-5, §33-25C-6, §33-25C-7, §33-25C-9 and §33-25C-11 of the Code of West Virginia, 1931, as amended, be repealed; and that said code be amended by adding thereto a new article, designated §33-16H-1, §33-16H-2, §33-16H-3 and §33-16H-4, all to read as follows:

**ARTICLE 16H. REVIEW OF ADVERSE DETERMINATIONS.**

**§33-16H-1. Definitions.**

1 As used in this article:

2 (1) "Adverse determination" means a determination by a  
3 health carrier or its designee utilization review organization that  
4 an admission, availability of care, continued stay or other  
5 healthcare service that is a covered benefit has been reviewed  
6 and, based upon the information provided, does not meet the  
7 health carrier's requirements for medical necessity,  
8 appropriateness, health care setting, level of care or  
9 effectiveness, and the requested service or payment for the  
10 service is therefore denied, reduced or terminated.

11 (2) "External review" means a review of a final adverse  
12 determination by an independent review organization.

13 (3) "Final adverse determination" means an adverse  
14 determination that has been upheld by the issuer at the  
15 completion of the internal grievance procedures or an adverse  
16 determination with respect to which the internal grievance  
17 procedures have been deemed exhausted.

18 (4) "Health benefit plan" means a policy, contract, certificate  
19 or agreement entered into, offered or issued by an issuer to  
20 provide, deliver, arrange for, pay for, or reimburse any of the  
21 costs of health care services, including short-term and  
22 catastrophic health insurance policies and policies that pay on a  
23 cost-incurred basis, but excludes the excepted benefits defined

24 in 42 U. S. C. §300gg-91 and policies, contracts, certificates or  
25 agreements excluded by rules promulgated pursuant to section  
26 four of this article.

27 (5) "Health plan issuer" or "issuer" means an entity required  
28 to be licensed under this chapter that contracts, or offers to  
29 contract to provide, deliver, arrange for, pay for, or reimburse  
30 any of the costs of health care services under a health benefit  
31 plan, including an accident and sickness insurance company, a  
32 health maintenance corporation, a health care corporation, a  
33 health or hospital service corporation, and a fraternal benefit  
34 society.

35 (6) "Independent review organization" means an entity  
36 approved by the commissioner to conduct external reviews of  
37 final adverse determinations.

38 (7) "Utilization review" means a system for the evaluation  
39 of the necessity, appropriateness and efficiency of the use of  
40 health care services, procedure and facilities.

### **§33-16H-2. Issuer requirements.**

1 An issuer shall, in accordance with rules promulgated  
2 pursuant to section four of this article, develop processes for  
3 utilization review and internal grievance procedures and shall  
4 make external review available with respect to all adverse  
5 determinations.

### **§33-16H-3. Judicial review; enforcement.**

1 (a) An individual or issuer may seek judicial review of a  
2 final decision rendered by an independent review organization  
3 by filing a petition in the circuit court within sixty days after  
4 receipt of notice of such decision.

5 (1) Venue for a petition filed pursuant to this section is the  
6 county in which the individual resides or, if the individual is a  
7 non-resident, the county in which he or she works or, if he or she

8 does not work in this state, the county in which his or her  
9 employer is located, or if none of these counties are applicable,  
10 in Kanawha County.

11 (2) The issuer shall provide benefits pursuant to the final  
12 external review decision, including by making payment on a  
13 disputed claim, unless or until there is a judicial decision  
14 otherwise.

15 (3) If the issuer files a petition pursuant to this section and  
16 the individual substantially prevails, the issuer shall be  
17 responsible for the reasonable attorney's fees of the individual.

18 (b) A decision issued by an independent review organization  
19 pursuant to this article may be enforced in the same manner as  
20 an order of the commissioner.

21 (c) This article does not create any new cause of action or  
22 eliminate any presently existing cause of action.

**§33-16H-4. Rule-making authority; applicability.**

1 (a) The commissioner shall propose legislative rules for  
2 approval by the Legislature in accordance with the provisions of  
3 article three, chapter twenty-nine-a of this code to implement the  
4 provisions of this article, including but not limited to rules to:

5 (1) Define the scope of the applicability of this article;

6 (2) Establish requirements for all issuers with regard to  
7 utilization review and for internal grievance procedures and  
8 external review of adverse determinations, which rules shall be  
9 based on the corresponding model acts adopted by the National  
10 Association of Insurance Commissioners and, with respect to  
11 external review, shall meet or exceed the minimum consumer  
12 protections established by the federal Patient Protection and  
13 Affordable Care Act (Public Law 111-148), as amended by the  
14 federal Health Care and Education Reconciliation Act of 2010  
15 (Public Law 111-152); and

16       (3) Provide for judicial review pursuant to subsection (a),  
17 section three of this article, which rules shall be based on the  
18 provisions of this code and rules governing judicial review of  
19 contested cases under the State Administrative Procedures Act.

20       (b) Notwithstanding the provisions of section one, article  
21 twenty-three of this chapter; section four, article twenty-four of  
22 this chapter; section six, article twenty-five of this chapter; and  
23 section twenty-four, article twenty-five-a of this chapter, this  
24 article and the rules promulgated under this article are applicable  
25 to all health benefits plans and supersede any provisions to the  
26 contrary in this chapter or in any rules promulgated under this  
27 chapter.

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

  
\_\_\_\_\_  
Chairman, House Committee

Member   
\_\_\_\_\_  
Chairman, Senate Committee

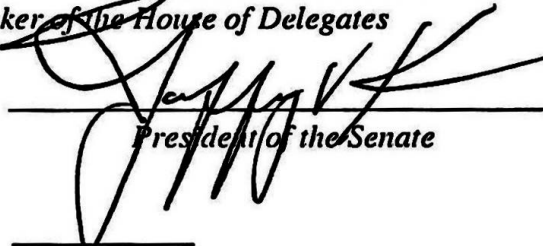
Originating in the House.

In effect ninety days from passage.

  
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Clerk of the House of Delegates

  
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Clerk of the Senate

  
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Speaker of the House of Delegates

  
\_\_\_\_\_  
President of the Senate

The within is approved this the 1st  
day of May, 2013.

  
\_\_\_\_\_  
Governor

**PRESENTED TO THE GOVERNOR**

**APR 29 2013**

Time 2:10 pm