WEST VIRGINIA CODE: §33-25A-2

§33-25A-2. Definitions.

(1) "Basic health care services" means physician, hospital, out-of-area, podiatric, chiropractic, laboratory, X ray, emergency, treatment for serious mental illness as provided in section three-a, article sixteen of this chapter, and cost-effective preventive services including immunizations, well-child care, periodic health evaluations for adults, voluntary family planning services, infertility services, and children's eye and ear examinations conducted to determine the need for vision and hearing corrections, which services need not necessarily include all procedures or services offered by a service provider.

(2) "Capitation" means the fixed amount paid by a health maintenance organization to a health care provider under contract with the health maintenance organization in exchange for the rendering of health care services.

(3) "Commissioner" means the Commissioner of Insurance.

(4) "Consumer" means any person who is not a provider of care or an employee, officer, director or stockholder of any provider of care.

(5) "Copayment" means a specific dollar amount, or percentage, except as otherwise provided for by statute, that the subscriber must pay upon receipt of covered health care services and which is set at an amount or percentage consistent with allowing subscriber access to health care services.

(6) "Employee" means a person in some official employment or position working for a salary or wage continuously for no less than one calendar quarter and who is in such a relation to another person that the latter may control the work of the former and direct the manner in which the work shall be done.

(7) "Employer" means any individual, corporation, partnership, other private association, or state or local government that employs the equivalent of at least two full-time employees during any four consecutive calendar quarters.

(8) "Enrollee", "subscriber" or "member" means an individual who has been voluntarily enrolled in a health maintenance organization, including individuals on whose behalf a contractual arrangement has been entered into with a health maintenance organization to receive health care services.

(9) "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee setting out the coverage and other rights to which the enrollee is entitled.

(10) "Health care services" means any services or goods included in the furnishing to any individual of medical, mental or dental care, or hospitalization or incident to the furnishing

of the care or hospitalization, osteopathic services, chiropractic services, podiatric services, home health, health education or rehabilitation, as well as the furnishing to any person of any and all other services or goods for the purpose of preventing, alleviating, curing or healing human illness or injury.

(11) "Health maintenance organization" or "HMO" means a public or private organization which provides, or otherwise makes available to enrollees, health care services, including at a minimum basic health care services and which:

(A) Receives premiums for the provision of basic health care services to enrollees on a prepaid per capita or prepaid aggregate fixed sum basis, excluding copayments;

(B) Provides physicians' services primarily: (i) Directly through physicians who are either employees or partners of the organization; or (ii) through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice arrangement; or (iii) through some combination of paragraphs (i) and (ii) of this subdivision;

(C) Assures the availability, accessibility and quality, including effective utilization, of the health care services which it provides or makes available through clearly identifiable focal points of legal and administrative responsibility; and

(D) Offers services through an organized delivery system in which a primary care physician or primary care provider is designated for each subscriber upon enrollment. The primary care physician or primary care provider is responsible for coordinating the health care of the subscriber and is responsible for referring the subscriber to other providers when necessary: Provided, That when dental care is provided by the health maintenance organization the dentist selected by the subscriber from the list provided by the health maintenance organization shall coordinate the covered dental care of the subscriber, as approved by the primary care physician or the health maintenance organization.

(12) "Impaired" means a financial situation in which, based upon the financial information which would be required by this chapter for the preparation of the health maintenance organization's annual statement, the assets of the health maintenance organization are less than the sum of all of its liabilities and required reserves including any minimum capital and surplus required of the health maintenance organization by this chapter so as to maintain its authority to transact the kinds of business or insurance it is authorized to transact.

(13) "Individual practice arrangement" means any agreement or arrangement to provide medical services on behalf of a health maintenance organization among or between physicians or between a health maintenance organization and individual physicians or groups of physicians, where the physicians are not employees or partners of the health maintenance organization and are not members of or affiliated with a medical group.

(14) "Insolvent" or "insolvency" means a financial situation in which, based upon the

financial information that would be required by this chapter for the preparation of the health maintenance organization's annual statement, the assets of the health maintenance organization are less than the sum of all of its liabilities and required reserves.

(15) "Medical group" or "group practice" means a professional corporation, partnership, association or other organization composed solely of health professionals licensed to practice medicine or osteopathy and of other licensed health professionals, including podiatrists, dentists and optometrists, as are necessary for the provision of health services for which the group is responsible: (a) A majority of the members of which are licensed to practice medicine or osteopathy; (b) who as their principal professional activity engage in the coordinated practice of their profession; (c) who pool their income for practice as members of the group and distribute it among themselves according to a prearranged salary, drawing account or other plan; and (d) who share medical and other records and substantial portions of major equipment and professional, technical and administrative staff.

(16) "Point of service option" means a delivery system that permits an enrollee to receive health care services from a provider outside of the panel of providers with which the health maintenance organization has a contractual arrangement under the terms and conditions of the enrollee's contract with the health maintenance organization or the insurance carrier that provides the point of service option.

(17) "Premium" means a prepaid per capita or prepaid aggregate fixed sum unrelated to the actual or potential utilization of services of any particular person which is charged by the health maintenance organization for health services provided to an enrollee.

(18) "Primary care physician" means the general practitioner, family practitioner, obstetrician/gynecologist, pediatrician or specialist in general internal medicine who is chosen or designated for each subscriber who will be responsible for coordinating the health care of the subscriber, including necessary referrals to other providers.

(19) "Primary care provider" means a person who may be chosen or designated in lieu of a primary care physician for each subscriber, who will be responsible for coordinating the health care of the subscriber, including necessary referrals to other providers, and includes:

(A) An advanced nurse practitioner practicing in compliance with article seven, chapter thirty of this code and other applicable state and federal laws, who develops a mutually agreed upon association in writing with a primary care physician on the panel of and credentialed by the health maintenance organization; and

(B) A certified nurse-midwife, but only if chosen or designated in lieu of a subscriber's primary care physician or primary care provider during the subscriber's pregnancy and for a period extending through the end of the month in which the sixty-day period following termination of pregnancy ends.

(C) Nothing in this subsection may be construed to expand the scope of practice for

advanced nurse practitioners as governed by article seven, chapter thirty of this code or any legislative rule, or for certified nurse-midwives, as defined in article fifteen, chapter thirty of this code.

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

(21) "Uncovered expenses" means the cost of health care services that are covered by a health maintenance organization, for which a subscriber would also be liable in the event of the insolvency of the organization.

(22) "Service area" means the county or counties approved by the commissioner within which the health maintenance organization may provide or arrange for health care services to be available to its subscribers.

(23) "Statutory surplus" means the minimum amount of unencumbered surplus which a corporation must maintain pursuant to the requirements of this article.

(24) "Surplus" means the amount by which a corporation's assets exceeds its liabilities and required reserves based upon the financial information which would be required by this chapter for the preparation of the corporation's annual statement except that assets pledged to secure debts not reflected on the books of the health maintenance organization shall not be included in surplus.

(25) "Surplus notes" means debt which has been subordinated to all claims of subscribers and general creditors of the organization.

(26) "Qualified independent actuary" means an actuary who is a member of the American academy of actuaries or the society of actuaries and has experience in establishing rates for health maintenance organizations and who has no financial or employment interest in the health maintenance organization.

(27) "Quality assurance" means an ongoing program designed to objectively and systematically monitor and evaluate the quality and appropriateness of the enrollee's care, pursue opportunities to improve the enrollee's care and to resolve identified problems at the prevailing professional standard of care.

(28) "Utilization management" means a system for the evaluation of the necessity, appropriateness and efficiency of the use of health care services, procedure and facilities.