WEST VIRGINIA CODE: §33-25A-4

§33-25A-4. Issuance of certificate of authority.

(1) Upon receipt of an application for a certificate of authority, the commissioner shall determine whether the application for a certificate of authority, with respect to health care services to be furnished, has demonstrated:

(a) The willingness and potential ability of the organization to assure that basic health services will be provided in a manner to enhance and assure both the availability and accessibility of adequate personnel and facilities;

(b) Arrangements for an ongoing evaluation of the quality of health care provided by the organization and utilization review which meet those standards required by the commissioner by rule; and

(c) That the organization has a procedure to develop, compile, evaluate and report statistics relating to the cost of its operations, the pattern of utilization of its services, the quality, availability and accessibility of its services and any other matters reasonably required by rule.

(2) The commissioner shall issue or deny a certificate of authority to any person filing an application within one hundred twenty days after receipt of the application. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed, if the commissioner is satisfied that the following conditions are met:

(a) The health maintenance organization's proposed plan of operation meets the requirements of subsection (1) of this section;(b) The health maintenance organization will effectively provide or arrange for the provision of at least basic health care services on a prepaid basis except for copayments: Provided, That nothing in this section shall be construed to relieve a health maintenance organization from the obligations to provide health care services because of the nonpayment of copayments unless the enrollee fails to make payment in at least three instances over any twelve-month period: Provided, however, That nothing in this section shall permit a health maintenance organization to charge copayments to Medicare beneficiaries or Medicaid recipients in excess of the copayments permitted under those programs, nor shall a health maintenance organization be required to provide services to the Medicare beneficiaries or Medicaid recipients in excess of the benefits compensated under those programs;

(c) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

(i) The financial soundness of the health maintenance organization's arrangements for health

care services and the proposed schedule of charges used in connection with the health care services;

(ii) That the health maintenance organization has and maintains the following:

(A) If a for-profit stock corporation, at least $1 million of fully paid-in capital stock; or

(B) If a nonprofit corporation, at least $1 million of statutory surplus funds; and

(C) Both for-profit and nonprofit health maintenance organization, additional surplus funds of at least $1 million;

(iii) Any arrangements that will guarantee for the continuation of benefits and payments to providers for services rendered both prior to and after insolvency for the duration of the contract period for which payment has been made, except that benefits to members who are confined on the date of insolvency in an inpatient facility shall be continued until their discharge; and

(iv) Any agreement with providers for the provision of health care services;

(d) Reasonable provisions have been made for emergency and out-of-area health care services;

(e) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to section six of this article;

(f) The health maintenance organization has demonstrated that it will assume full financial risk on a prospective basis for the provision of health care services, including hospital care: Provided, That the requirement of this subdivision shall not prohibit a health maintenance organization from obtaining reinsurance acceptable to the commissioner from an accredited reinsurer or making other arrangements acceptable to the commissioner:

(i) For the cost of providing to any enrollee health care services, the aggregate value of which exceeds $4,000 in any year;

(ii) For the cost of providing health care services to its members on a nonelective emergency basis, or while they are outside the area served by the organization; or

(iii) For not more than ninety-five percent of the amount by which the health maintenance organization's costs for any of its fiscal years exceed one hundred five percent of its income for those fiscal years;

(g) The ownership, control and management of the organization is competent and trustworthy and possesses managerial experience that would make the proposed health maintenance organization operation beneficial to the subscribers. The commissioner may, at his or her discretion, refuse to grant or continue authority to transact the business of a

health maintenance organization in this state at any time during which the commissioner has probable cause to believe that the ownership, control or management of the organization includes any person whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors or creditors;

(h) The health maintenance organization has deposited and maintained in trust with the State Treasurer, for the protection of its subscribers or its subscribers and creditors, cash or government securities eligible for the investment of capital funds of domestic insurers as described in paragraph (A) or (B), subdivision (1), subsection (a), section eleven, article eight of this chapter or paragraph (A), (B) or (C), subdivision (3) of said subsection, in the amount of $100,000; and

(i) The health maintenance organization has a quality assurance program which has been reviewed by the commissioner or by a nationally recognized accreditation and review organization approved by the commissioner; meets at least those standards set forth in section seventeen-a of this article; and is determined satisfactory by the commissioner. If the commissioner determines that the quality assurance program of a health maintenance organization is deficient in any significant area, the commissioner, in addition to other remedies provided in this chapter, may establish a corrective action plan that the health maintenance organization must follow as a condition to the issuance of a certificate of authority: Provided, That in those instances where a health maintenance organization has timely applied for and reasonably pursued a review of its quality assurance program, but the review has not been completed, the health maintenance organization shall submit proof to the commissioner of its application for that review.

(3) A certificate of authority shall be denied only after compliance with the requirements of section twenty-one of this article.

(4) No person who has not been issued a certificate of authority shall use the words "health maintenance organization" or the initials "HMO" in its name, contracts, logo or literature: Provided, That persons who are operating under a contract with, operating in association with, enrolling enrollees for, or otherwise authorized by a health maintenance organization licensed under this article to act on its behalf may use the terms "health maintenance organization", or "HMO" for the limited purpose of denoting or explaining their association or relationship with the authorized health maintenance organization. No health maintenance organization which has a minority of board members who are consumers shall use the words "consumer controlled" in its name or in any way represent to the public that it is controlled by consumers.