WEST VIRGINIA CODE: §33-25D-11

§33-25D-11. Evidence of coverage; review of enrollee records; charges for limited health services; cancellation of contract by enrollee.

(a)(1) Every enrollee is entitled to evidence of coverage in accordance with this section. The prepaid limited health service organization or its designated representative shall issue the evidence of coverage.

(2) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the commissioner.

(3) An evidence of coverage shall contain a clear, concise and complete statement of:

(A) The limited health service and the insurance or other benefits, if any, to which the enrollee is entitled;

(B) Any exclusions or limitations on the service, kind of service, benefits, or kind of benefits, to be provided, including any copayments;

(C) Where and in what manner information is available as to how a service may be obtained: Provided, That with respect to any limited health service for which inpatient services, hospital surgical services or emergency services are provided, the evidence of coverage shall contain a definition of inpatient services, hospital surgical services or emergency services, respectively; describe procedures for determination by the prepaid limited health service organization of whether the services qualify for reimbursement as inpatient services, hospital surgical services or emergency services; and contain specific examples of situations in which the services would be made available;

(D) The total amount of payment and copayment, if any, for the limited health service and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates;

(E) A description of the prepaid limited health service organization's method for resolving enrollee grievances; and

(F) The following exact statement in bold print:

"Each subscriber or enrollee, by acceptance of the benefits described in this evidence of coverage, consents to the examination of his or her medical records for purposes of utilization review, quality assurance and peer review by the prepaid limited health service organization or its designee."

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(4) Any subsequent approved change in an evidence of coverage shall be issued to each enrollee.

(5) A copy of the form of the evidence of coverage to be used in this state, and any amendment thereto, is subject to the filing and approval requirements of subdivision (2), subsection (a) of this section, unless the commissioner promulgates a rule dispensing with this requirement or unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or hospital, medical, dental or health service corporations, in which event the filing and approval provisions of those laws apply. To the extent, however, that those provisions do not apply the requirements in subdivision (3), subsection (a) of this section, are applicable.

(b)(1) Premiums for each limited health service offered may be established in accordance with actuarial principles: Provided, That premiums may not be excessive, inadequate, or unfairly discriminatory. A certification by a qualified independent actuary shall accompany a rate filing for each limited health service offered and shall certify that:

(A) The rates are neither inadequate nor excessive nor unfairly discriminatory;

(B) That the rates are appropriate for the classes of risks for which they have been computed;

(C) Provide an adequate description of the rating methodology showing that the methodology follows consistent and equitable actuarial principles; and

(D) The rates being charged are actuarially adequate to the end of the period for which rates have been guaranteed.

(2) In determining whether the charges are reasonable, the commissioner shall consider whether the prepaid limited health service organization has:

(A) Made a vigorous, good faith effort to control rates paid to limited health service providers;

(B) Established a premium schedule, including copayments, if any, which encourages enrollees to seek out preventive limited health services; and

(C) Made a good faith effort to secure arrangements whereby the limited health service can be obtained by subscribers from local providers to the extent that the providers offer the services.

(c) Rates for a particular limited health service are inadequate if the premiums derived from the rating structure, plus investment income, copayments, and revenues from coordination of benefits and subrogation, fees-for-service and reinsurance recoveries are not set at a level at least equal to the anticipated cost of benefits for the limited health service during the period for which the rates are to be effective and the other expenses which would be

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incurred if other expenses were at the level for the current or nearest future period during which the prepaid limited health service organization is projected to make a profit. For this analysis, total investment income added to premiums, copayments and revenues from coordination of benefits and subrogation, fees-for-service and reinsurance recoveries with respect to all limited health services offered may not exceed three percent of the prepaid limited health service organization's total projected revenues.

(d) The commissioner shall within a reasonable period approve any form if the requirements of subsection (a) of this section are met and any schedule of charges if the requirements of subsections (b) and (c) of this section are met. It is unlawful to issue the form or to use the schedule of charges until approved. If the commissioner disapproves of the filing, he or she shall notify the filer promptly. In the notice, the commissioner shall specify the reasons for his or her disapproval and the findings of fact and conclusions which support his or her reasons. A hearing will be granted by the commissioner within forty-five days after a request in writing, by the person filing, has been received by the commission. If the commissioner does not disapprove any form or schedule of charges within sixty days of the filing of the forms or charges, they are approved.

(e) The commissioner may require the submission of whatever relevant information in addition to the schedule of charges which he or she considers necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(f) An individual enrollee may cancel a contract with a prepaid limited health service organization at any time for any reason: Provided, That a prepaid limited health service organization may require that the enrollee give thirty days advance notice: Provided, however, That an individual enrollee whose premium rate was determined pursuant to a group contract may cancel a contract with a prepaid limited health service organization pursuant to the terms of that contract.

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