# WEST VIRGINIA CODE: §33-25D-2

**§33-25D-2. Definitions.**

(a) "Capitation" means the fixed amount paid by a prepaid limited health service organization to a health care provider under contract with the prepaid limited health service organization in exchange for the rendering of no more than four limited health services.

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

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

(d) "Coordinating provider" means the provider of a particular limited health service who is chosen or designated for each subscriber and who will be responsible for coordinating the provision of that particular limited health service to the subscriber, including necessary referrals to other providers of the limited health service: Provided, That if a subscriber is also enrolled in a health maintenance organization, the coordinating provider shall send a written report at least annually to the subscriber's primary care physician, as defined in article twenty-five-a of this chapter, describing the limited health service provided to the subscriber: Provided, however, That the coordinating provider may disclose data or information only as permitted under section twenty-eight of this article.

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

(f) "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 is done.

(g) "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.

(h) "Enrollee," "subscriber," or "member" means an individual who has been voluntarily enrolled in a prepaid limited health service organization, including individuals on whose behalf a contractual arrangement has been entered into with a prepaid limited health service organization to receive no more than four limited health services.

(i) "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.

(j) "Group practice" means a professional corporation, partnership, association, or other organization composed solely of health professionals licensed to practice medicine or osteopathy and of such other licensed health professionals, including podiatrists, dentists, optometrists and chiropractors, as are necessary for the provision of limited health services for which the group is responsible:

(1) A majority of the members of which are licensed to practice medicine, osteopathy or chiropractic;

(2) Who as their principal professional activity engage in the coordinated practice of their profession;

(3) 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

(4) Who share medical and other records and substantial portions of major equipment and professional, technical and administrative staff.

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

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

(m) "Insolvent" or "insolvency" means a financial situation in which, based upon the financial information which would be required by this chapter for the preparation of the prepaid limited health service organization's annual statement, the assets of the prepaid limited health service organization are less than the sum of all of its liabilities and required reserves.

(n) "Limited health service" means mental or behavioral health services (including mental illness, mental retardation, developmental disabilities, substance abuse, and chemical dependency services), dental care services, vision care services, podiatric care services, pharmaceutical services (including Medicare prescription drug plans), together with any services or goods included in the furnishing to any individual of a limited health service. "Limited health service" does not include inpatient services, hospital surgical services or

emergency services except as such services are provided incident to and directly related to a limited health service set forth in this subsection.

(o) "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 prepaid limited health service organization for health services provided to an enrollee.

(p) "Prepaid limited health service organization" means a public or private organization which provides, or otherwise makes available to enrollees, no more than four limited health services and which:

(1) Receives premiums for the provision of no more than four limited health services to enrollees on a prepaid per capita or prepaid aggregate fixed sum basis, excluding copayments;

(2) Provides no more than four limited health services primarily:

(A) Directly through an exclusive panel of physicians or other providers who are employees or partners of the organization;

(B) Through arrangements with individual physicians or other providers or one or more groups of physicians or other providers organized on a group practice or individual practice arrangement; or

(C) Some combination of paragraphs (A) and (B) of this subdivision;

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

(4) Offers services through an organized delivery system, in which a coordinating provider of a limited health service is designated for each subscriber to that limited health service. Prepaid limited health service organization does not include an entity otherwise authorized pursuant to the laws of this state to indemnify for any limited health service, or a provider or entity when providing a limited health service pursuant to a contract with a prepaid limited health service organization, a health maintenance organization, a health insurer or a self-insurance plan.

(q) "Provider" means any physician or other person or organization licensed or otherwise authorized in this state to furnish a limited health service.

(r) "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 prepaid limited health service organizations and who has no financial or employment interest in the prepaid limited health service organization.

(s) "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 resolve identified problems at the prevailing professional standard of care.

(t) "Service area" means the county or counties approved by the commissioner within which the prepaid limited health service organization may provide or arrange for a limited health service to be available to its subscribers.

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

(v) "Surplus" means the amount by which a corporation's assets exceed 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 prepaid limited health service organization shall not be included in surplus.

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

(x) "Uncovered expenses" means the cost of a limited health service covered by a prepaid limited health service organization, for which a subscriber would also be liable in the event of the insolvency of the organization.

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