WEST VIRGINIA CODE: §33-25D-3

§33-25D-3. Application for certificate of authority; addition of services.

(a) Notwithstanding any law of this state to the contrary, any person may apply to the commissioner for and obtain a certificate of authority to establish or operate a prepaid limited health service organization in compliance with this article: Provided, That the organization for which a certificate of authority to operate a prepaid limited health service organization is sought shall be incorporated under the provisions of article one, chapter thirty-one of this code. No person may sell prepaid limited health service organization enrollee contracts, nor may any prepaid limited health service organization commence services, prior to receipt of a certificate of authority from the commissioner. Any person may, however, establish the feasibility of a prepaid limited health service organization prior to receipt of a certificate of authority through funding drives and by receiving loans and grants.

(b) Every prepaid limited health service organization in operation as of the effective date of this article shall submit an application for a certificate of authority under this section within thirty days of the effective date of this article. Each applicant may continue to operate until the commissioner acts upon the application. In the event that an application is denied pursuant to section five of this article, the applicant shall be treated as a prepaid limited health service organization whose certificate of authority has been revoked.

(c) The commissioner may require any organization providing or arranging for one or more limited health services on a prepaid per capita or prepaid aggregate fixed sum basis to apply for a certificate of authority under this article. Any organization directed to apply for a certificate of authority is subject to the provisions of subsection (b) of this section.

(d) Each application for a certificate of authority shall be sworn to by an officer or authorized representative of the applicant before a notary public, shall be in a form prescribed by the commissioner and shall set forth or be accompanied by any and all information required by the commissioner, including:

(1) The basic organizational document;

(2) The bylaws or rules;

(3) A list of the names, addresses and official positions of each member of the governing body, which shall contain a full disclosure in the application of any financial interest by the officer or member of the governing body or any provider or any organization or corporation owned or controlled by that person and the prepaid limited health service organization and the extent and nature of any contract or financial arrangements between that person and the prepaid limited health service organization;

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(4) A description of the prepaid limited health service organization and the limited health service or services to be offered;

(5) A copy of each evidence of coverage form and of each enrollee contract form;

(6) Financial statements which include the assets, liabilities and sources of financial support of the applicant and any corporation or organization owned or controlled by the applicant;

(7)(A) A description of the proposed method of marketing the plan;

(B) A schedule of proposed charges; and

(C) A financial plan which includes a three-year projection of the expenses and income and other sources of future capital;

(8) A power of attorney duly executed by the applicant, if not domiciled in this state, appointing the commissioner and his or her successors in office, and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action or proceeding against the prepaid limited health service organization on a cause of action arising in this state may be served;

(9) A statement reasonably describing the service area or areas to be served and the type or types of enrollees to be served;

(10) A description of the complaint procedures to be utilized as required under section fourteen of this article;

(11) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under section eight of this article;

(12) A complete biographical statement on forms prescribed by the commissioner and an independent investigation report on all of the individuals referred to in subdivision (3) of this subsection and all officers, directors and persons holding five percent or more of the common stock of the organization;

(13) A comprehensive feasibility study, performed by a qualified independent actuary in conjunction with a certified public accountant which shall contain a certification by the qualified actuary and an opinion by the certified public accountant as to the feasibility of the proposed organization. The study shall be for the greater of three years or until the prepaid limited health service organization has been projected to be profitable for twelve consecutive months. The study shall show that the prepaid limited health service organization would not, at the end of any month of the projection period, have less than the minimum capital and surplus as required by section six of this article. The qualified independent actuary shall certify that:

(A) The rates for each limited health service offered are neither inadequate nor excessive

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nor unfairly discriminatory;

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

(C) The rating methodology is appropriate: Provided, That the certification shall include an adequate description of the rating methodology showing that the methodology follows consistent and equitable actuarial principles;

(D) The prepaid limited health service organization is actuarially sound: Provided, That the certification shall consider the rates, benefits, and expenses of, and any other funds available for the payment of obligations of, the organization;

(E) The rates being charged or to be charged are actuarially adequate to the end of the period for which rates have been guaranteed; and

(F) Incurred but not reported claims and claims reported but not fully paid have been adequately provided for;

(14) A description of the prepaid limited health service organization's quality assurance program; and

(15) Such other information as the commissioner may require to be provided.

(e) A prepaid limited health service organization shall, unless otherwise provided for by rules promulgated by the commissioner, file notice prior to any modification of the operations or documents filed pursuant to this section or as the commissioner may require by rule. If the commissioner does not disapprove of the filing within ninety days of filing, it is considered approved and may be implemented by the prepaid limited health service organization: Provided, That an application to add one or more limited health services to those offered by the organization shall be submitted and reviewed in accordance with subsection (f) of this section.

(f) If a prepaid limited health service organization wishes to offer one or more additional limited health services to subscribers, the organization shall submit an application in accordance with the procedure set forth in subsection (d) of this section, with respect to the additional service or services: Provided, That the organization may not at any time offer more than four limited health services. The organization is not required to submit the information required by subdivisions (1), (2), (3), (8), (10), (11) or (12), subsection (d) of this section, if there has been no change in the information required by the respective subdivisions since the information was most recently filed with the commissioner.

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