WEST VIRGINIA LEGISLATURE
REGULAR SESSION, 1977

ENROLLED
SENATE BILL NO. 389

(By Mr. Hatfield)

PASSED April 9, 1977
In Effect ninety days from Passage
AN ACT to amend chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, by adding thereto a new article, designated article twenty-five-a, relating to establishing health maintenance organizations; issuance of certificate of authority; powers of health maintenance organizations; fiduciary responsibilities; approval of contracts; evidence of coverage and charges for health care services; annual report; information to enrollees; enrollment; complaint system; investments; prohibited practices; regulation of marketing; examinations; suspension or revocation of certificate of authority; rehabilitation, liquidation or conservation of health maintenance organizations; regulations; administrative procedures; fees; penalties and enforcement; filings and reports as public documents; confidentiality of medical information; authority to contract with health maintenance organizations under medicaid; and required health maintenance organization option.

Be it enacted by the Legislature of West Virginia:

That chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended by adding thereto a new article, designated article twenty-five-a, to read as follows:

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

1 (a) This article may be cited as the “Health Maintenance Organization Act of 1977.”

3 (b) Faced with the continuation of mounting costs of health care coupled with its inaccessibility to large segments of the population, the Legislature has determined that there is a need to encourage alternative
methods for the delivery of health care services, with a view toward achieving greater efficiency, availability, distribution, and economy in providing these services.

In carrying out this intention, it is the policy of the state to eliminate legal barriers to the establishment of prepaid health care plans accountable to consumers for the health care services they provide; to provide for the financial and administrative soundness of these health care plans as it relates to their ability to provide such services, and to exempt prepaid health care plans from regulation as an insurer, the operation of insurance laws of the state and all other laws inconsistent with the purposes of this article.


(1) “Basic health care services” means physician, hospital, out-of-area, podiatric, laboratory, X-ray, emergency, short-term mental health services not exceeding twenty outpatient visits in any twelve-month period, 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.

(2) “Commissioner” means the commissioner of insurance.

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

(4) “Copayment” means a nominal payment required of enrollees as a condition of the receipt of specific health services.

(5) “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.

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

(7) "Enrollee" 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.

(8) "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.

(9) "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 such care of hospitalization, osteopathic services, home health, health education, 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.

(10) "Health maintenance organization" 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:

(a) Is compensated except for copayments for the provision of basic health care services to enrollees solely on a predetermined periodic rate basis;

(b) Provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis, or (iii) through some combination of (i) and (ii) above;

(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.
(11) "Individual practice basis" 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 such health maintenance organization and are not members of or affiliated with a medical group.

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

(13) "Premium" means a predetermined periodic rate 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.

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

(15) "Service area" means the area identified by a health maintenance organization as the area within which health care services will be provided by the health maintenance organization.


(1) 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 health maintenance organization in compliance with this article. No person shall sell health maintenance organization enrollee contracts, nor shall any health maintenance organization commence services, prior to receipt of a certificate of authority. Any person may, however, establish the feasibility of a health maintenance organization prior to receipt of authority through funding drives and by receiving loans, grants and preliminary payments. The commissioner shall promulgate regulations in accordance herewith establishing methods of determining the feasibility of operating prospective health maintenance organizations.

(2) Every health maintenance 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 such applicant may continue to operate until the commissioner acts upon the application. In the event that an application is denied pursuant to section four of this article, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked.

(3) The commissioner may require any organization providing or arranging for health care services on a predetermined periodic rate to apply for a certificate of authority under this article. Any organization directed to apply for a certificate of authority shall be subject to the provisions of subsection (2) of this section.

(4) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, 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 (a) the basic organizational document; (b) the bylaws or rules and regulations; (c) 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 such officer or member of the governing body or any provider or any organization or corporation owned or controlled by such
person and the health maintenance organization and the extent and nature of any contract or financial arrangements between such persons and the health maintenance organization; (d) description of the health maintenance organization; (e) a copy of each evidence of coverage form and of each enrollee contract form; (f) 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; (g) (i) a description of the proposed method of marketing the plan, (ii) a schedule of proposed charges, and (iii) a financial plan which includes a three-year projection of the expenses and income and other sources of future capital; (h) a power of attorney duly executed by such applicant, if not domiciled in this state, appointing the commissioner and his successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served; (i) a statement reasonably describing the geographic area or areas to be served and the type or types of enrollees to be served; (j) a description of the complaint procedures to be utilized as required under section twelve of this article; (k) a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under section six of this article; and (l) such other information as the commissioner may require to be provided.

(5) A health maintenance organization shall, unless otherwise provided for by regulations 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 regulation. If the commissioner does not disapprove of the filing within thirty days of filing, it shall be deemed approved and may be implemented by the health maintenance organiza-

(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 to assure that basic health services will be provided in such a manner as 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;

(c) 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 such other matters as may be reasonably required by regulation.

(2) The commissioner shall issue or deny a certificate of authority to any person filing an application within sixty 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 provisions of at least basic health care services on a prepaid basis except for copayments: Provided, That nothing herein 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 herein 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 such medicare beneficiaries in excess of the copayments permitted under those programs.
beneficiaries or medical recipients in excess of the benefits compensated under such 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 proposed schedule of charges used in connection therewith;

(ii) The adequacy of working capital;

(iii) Any arrangements which will guarantee for a reasonable period of time the continued availability or payment of the cost of health care services in the event of discontinuance of the plan;

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

(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 in this paragraph shall not prohibit a health maintenance organization from obtaining insurance or making other arrangements (i) for the cost of providing to any enrollee comprehensive health maintenance services, the aggregate value of which exceeds four thousand dollars in any year, (ii) for the cost of providing comprehensive 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 such fiscal years.
(3) A certificate of authority shall be denied only after compliance with the requirements of section twenty-one of this article.

(4) Except as provided in subsection (2), section three of this article, 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 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.


1 Upon obtaining a certificate of authority as required under this article, a health maintenance organization may enter into health maintenance contracts in this state and engage in any activities, consistent with the purposes and provisions of this article, which are necessary to the performance of its obligations under such contracts, subject to the limitations provided for in this article. The commissioner may promulgate rules and regulations limiting or regulating the powers of health maintenance organizations which he finds to be in the public interest.


1 (1) The governing body of any health maintenance organization may include enrollees, providers, or other individuals.

2 (2) Such governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on
§33-25A-7. Fiduciary responsibilities; approval of contracts.

(a) Any director, officer or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the enrollees.

(b) Any contracts made with hospitals and practitioners of medical, dental and related services enabling a health maintenance organization to provide health care services authorized under this article shall be filed with the commissioner. The commissioner shall have power to require immediate renegotiation of such contracts whenever he determines that they provide for excessive payments, or that they fail to include reasonable incentives for cost control, or that they otherwise substantially and unreasonably contribute to escalation of the costs of providing health care services to enrollees.

§33-25A-8. Evidence of coverage and charges for health care services.

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

(b) 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.

(c) An evidence of coverage shall contain a clear, concise and complete statement of (i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled; (ii) any exclusions or limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any copayments; (iii) where and in what manner information is available as to how services, including emergency and out-of-area services, may be obtained; (iv) the total amount
of payment and copayment, if any, for health care services 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; and (v) a description of the health maintenance organization's method for resolving enrollee complaints.

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

(e) A copy of the form of the evidence of coverage to be used in this state, and any amendment thereto, shall be subject to the filing and approval requirements of subdivision (b), subsection (1) of this section, unless the commissioner promulgates a regulation dispensing with this requirement or unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or, hospital or medical service corporations, in which event the filing and approval provisions of such laws shall apply. To the extent, however, that such provisions do not apply the requirements in subdivision (c), subsection (1) of this section, shall be applicable.

(2) Such charges may be established in accordance with actuarial principles: Provided, That premiums shall not be excessive, inadequate, or unfairly discriminatory. A certification by a qualified actuary, to the appropriateness of the charges based on reasonable assumptions shall accompany the filing along with adequate supporting information. In determining whether such charges are reasonable, the commissioner shall consider whether such health maintenance organization has (a) made a vigorous, good faith effort to control rates paid to health care providers; and (b) established a premium schedule, including copayments, if any, which encourages enrollees to seek out preventive health care services.

(3) The commissioner shall within a reasonable period approve any form if the requirements of subsection (1) are met and any schedule of charges if the requirements of subsection (2) are met. It shall be unlawful to issue such form or to use such schedule of charges until approved. If the commissioner disapproves of such filing,
he shall notify the filer promptly. In the notice, the commis-
missioner shall specify the reasons for his disapproval
and the findings of fact and conclusions which support
his reasons. A hearing will be granted by the commis-
ioner within fifteen 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 sched-
ule of charges within sixty days of the filing of such
forms or charges, they shall be deemed approved.

(4) The commissioner may require the submission of
whatever relevant information in addition to the sched-
ule of charges which he deems necessary in determining
whether to approve or disapprove a filing made pursuant
to this section.

(5) An enrollee shall be allowed to cancel a contract
with a health maintenance organization at any time for
any reason provided that a health maintenance organiza-
tion may require that he or she give thirty days' notice
of disenrollment to such organization.


(1) Every health maintenance organization shall
annually, on or before the first day of March, file a report
verified by at least two principal officers with the com-
missioner, covering the preceding calendar year.

(2) Such report shall be on forms prescribed by the
commissioner and shall include:

(a) A financial statement of the organization, including
its balance sheet and receipts and disbursements for the
preceding year certified by an independent certified
public accountant, reflecting at least (i) all prepayment
and other payments received for health care services
rendered, (ii) expenditures to all providers, by classes or
groups of providers, and insurance companies or nonprofit
health service plan corporations engaged to fulfill obli-
gations arising out of the health maintenance contract,
and (iii) expenditures for capital improvements, or
additions thereto, including, but not limited to, construc-
tion, renovation or purchase of facilities and capital
equipment;
(b) The number of new enrollees enrolled during the year, the number of enrollees as of the end of the year and the number of enrollees terminated during the year;

(c) A summary of information compiled pursuant to subdivision (c), subsection (1), section four of this article in such form as may be required by the department of health;

(d) A report of the names and residence addresses of all persons set forth in subdivision (c), subsection (4), section three of this article who were associated with the health maintenance organization during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to the health maintenance organization, including a full disclosure of all financial arrangements during the preceding year required to be disclosed pursuant to subdivision (c), subsection (4), section three of this article; and

(e) Such other information relating to the performance of the health maintenance organization as is reasonably necessary to enable the commissioner to carry out his duties under this article.

§33-25A-10. Information to enrollees.

Every health maintenance organization or its representative shall annually, before the first day of April, provide to its enrollees a summary of: Its most recent annual financial statement including a balance sheet and statement of receipts and disbursements; a description of the health maintenance organization, its basic health care services, its facilities and personnel, any material changes therein since the last report, the current evidence of coverage, and a clear and understandable description of the health maintenance organization’s method for resolving enrollee complaints: Provided, That with respect to enrollees who have been enrolled through contracts between a health maintenance organization and an employer, the health maintenance organization shall be deemed to have satisfied the requirement of the section by providing the requisite summary to each enrolled employee.

1 (1) Once a health maintenance organization has been in operation at least five years, or has enrollment of not less than fifty thousand persons, such health maintenance organization shall, in any year following a year in which the health maintenance organization has achieved an operating surplus, maintain an open enrollment period of at least thirty days during which time the health maintenance organization shall, within the limits of its capacity, accept individuals in the order in which they apply without regard to preexisting illness, medical conditions, or degree of disability except for individuals who are confined to an institution because of chronic illness or permanent injury: Provided, That no health maintenance organization shall be required to continue an open enrollment period after such time as enrollment pursuant to such open enrollment period is equal to three percent of the health maintenance organization's net increase in enrollment during the previous year.

2 (2) Where a health maintenance organization demonstrates to the satisfaction of the commissioner that it has a disproportionate share of high-risk enrollees and that, by maintaining open enrollment, it would be required to enroll so disproportionate a share of high-risk enrollees as to jeopardize its economic viability, the commissioner may:

3 (a) Waive such requirement for open enrollment for a period of not more than three years; or

4 (b) Authorize such organization to impose such underwriting restrictions upon open enrollment as are necessary (i) to preserve its financial stability; (ii) to prevent excessive adverse selection by prospective enrollees; or (iii) to avoid unreasonably high or unmarketable charges for enrollee coverage of health services. A health maintenance organization may receive more than one such waiver or authorization.

5 (3) The enrollment by a health maintenance organization of medicare beneficiaries who are at least sixty-five years of age and medicaid beneficiaries shall not exceed fifty percent of its total enrollee population. The commissioner may waive this requirement with respect to any
health maintenance organization intending to enroll at least forty percent of its enrollees from medically underserved areas, as defined by the commissioner, if he is satisfied that such organization is making substantial progress toward achieving compliance.


1 (1) A health maintenance organization shall establish and maintain a complaint system, which has been approved by the commissioner, to provide adequate and reasonable procedures for the expeditious resolution of written complaints initiated by enrollees concerning any matter relating to any provisions of such organization’s health maintenance contracts, including, but not limited to, claims regarding the scope of coverage for health care services; denials, cancellations, or nonrenewals of enrollee coverage; observance of an enrollee’s rights as a patient; and the quality of the health care services rendered.

2 (2) A health maintenance organization shall give a timely and reasoned response, in writing, to each written complaint it receives. Copies of such complaints and the responses thereto shall be available to the commissioner, and the public for inspection for three years.

3 (3) Each health maintenance organization shall submit to the commissioner an annual report in a form prescribed by the commissioner which describes such complaint system and contains a compilation and analysis of the complaints filed, their disposition, and their underlying causes.


1 With the exception of investments otherwise made in accordance with this article, the investable funds of a health maintenance organization shall be invested only in securities or other investments permitted by the laws of this state for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the commissioner may permit.


1 (1) No health maintenance organization, or representative thereof, may cause or knowingly permit the use of
advertising which is untrue or misleading, solicitation
which is untrue or misleading, or any form of evidence
of coverage which is deceptive. For purposes of this
article:
(a) A statement or item of information shall be deemed
to be untrue if it does not conform to fact in any respect
which is or may be significant to an enrollee of, or person
considering enrollment in, a health maintenance orga-
nization;
(b) A statement or item of information shall be deemed
to be misleading, whether or not it may be literally
untrue, if, in the total context in which such statement
is made or such item of information is communicated,
such statement or item of information may be reasonably
understood by a reasonable person, not possessing special
knowledge regarding health care coverage, as indicating
any benefit or advantage or the absence of any exclusion,
limitation, or disadvantage of possible significance to an
enrollee of, or person considering enrollment in, a health
maintenance organization, if such benefit or advantage or
absence of limitation, exclusion or disadvantage does not
in fact exist;
(c) An evidence of coverage shall be deemed to be
deceptive if the evidence of coverage taken as a whole,
and with consideration given to typography and format,
as well as language, shall be such as to cause a reasonable
person, not possessing special knowledge regarding health
maintenance organizations, and evidences of coverage
therefor, to expect benefits, services, or other advantages
which the evidence of coverage does not provide or which
the health maintenance organization issuing such evidence
of coverage does not regularly make available for enrollees
covered under such evidence of coverage; and
(d) The commissioner may further define practices
which are untrue, misleading, or deceptive.
(2) No health maintenance organization may cancel or
fail to renew the coverage of an enrollee except for (a)
failure to pay the charge for health care coverage; (b)
termination of the health maintenance organization; (c)
termination of the group plan; (d) enrollee moving out of
the area served; (e) enrollee moving out of an eligible group; or (f) other reasons established in regulations promulgated by the commissioner. No health maintenance organization shall use any technique of rating or grouping to cancel or fail to renew the coverage of an enrollee. An enrollee shall be given thirty days’ notice of any cancellation or nonrenewal, including therein the reason therefor: Provided, That each enrollee moving out of an eligible group shall be granted the opportunity to enroll in the health maintenance organization on an individual basis.

A health maintenance organization may not disenroll an enrollee for nonpayment of copayments unless the enrollee has failed to make payment in at least three instances over any twelve-month period; however, the enrollee may not be disenrolled if the disenrollment would constitute abandonment of a patient. Any enrollee wrongfully disenrolled shall be reenrolled.

(3) No health maintenance organization may use in its name, contracts, or literature any of the words “insurance,” “casualty,” “surety,” “mutual,” or any other words which are descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state: Provided, That when a health maintenance organization has contracted with an insurance company for any coverage permitted by this article, it may so state.

(4) The providers under agreement with a health maintenance organization to provide health care services and the health maintenance organization shall not have recourse against enrollees for amounts above those specified in the evidence of coverage as the periodic prepayment, or copayment, for health care services.

(5) No health maintenance organization shall enroll more than three hundred thousand persons in this state.

(6) No health maintenance organization shall discriminate in enrollment policies or quality of services against any person on the basis of race, sex, age, religion, place of residence, health status, or source of payment:
Provided. That differences in rates based on valid actuarial distinctions, including, distinctions relating to age and sex, shall not be considered discrimination in enrollment policies.

(7) No agent of a health maintenance organization or person selling enrollments in a health maintenance organization shall sell an enrollment in a health maintenance organization unless such agent or person shall first disclose in writing to the prospective purchaser the following information using the following exact terms in bold print: (a) "Services offered," including any exclusions or limitations; (b) "full cost," including copayments; (c) "facilities available and hours of services"; (d) "transportation services"; (e) "disenrollment rate"; and (f) "staff," including the names of all full-time staff physicians, consulting specialists, hospitals and pharmacies associated with the health maintenance organization. In any home solicitation, any three-day cooling-off period applicable to consumer transactions generally shall apply in the same manner as consumer transactions.

The form disclosure statement shall not be used in sales until it has been approved by the commissioner or submitted to the commissioner for ten days without disapproval. Any person who fails to disclose the requisite information prior to the sale of an enrollment may be held liable in an amount equivalent to one year's subscription rate to the health maintenance organization, plus costs and a reasonable attorney's fee.

(8) No contract with an enrollee shall prohibit an enrollee from canceling his or her enrollment at any time for any reason except that such contract may require thirty days' notice to the health maintenance organization.

(9) Any person who in connection with an enrollment violates any subsection of this section may be held liable for an amount equivalent to one year's subscription rate, plus costs and a reasonable attorney's fee.


The commissioner may, in his discretion, after notice and hearing, promulgate rules and regulations as are
necessary to regulate marketing of health maintenance organizations by persons compensated directly or indirectly by such health maintenance organizations. When necessary such rules and regulations may prohibit door-to-door solicitations, may prohibit commission sales, and may provide for such other proscriptions and other regulations as are required to effectuate the purposes of this article.


(1) An insurance company licensed in this state, or a hospital or medical service corporation authorized to do business in this state, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this article. Notwithstanding any other law which may be inconsistent herewith, any two or more such insurance companies, hospital or medical service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(2) Notwithstanding any provision of insurance and hospital or medical service corporation laws, an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

§33-25A-17. Examinations.

(1) The commissioner may make an examination of the affairs of any health maintenance organization and pro-
viders with whom such organization has contracts, agree-
ments or other arrangements as often as he deems it
ecessary for the protection of the interests of the people
of this state but not less frequently than once every three
years.

(2) The commissioner shall contract with the depart-
ment of health to make examinations concerning the
quality of health care services of any health maintenance
organization and providers with whom such organization
has contracts, agreements or other arrangements as often
as it deems necessary for the protection of the interests
of the people of this state but not less frequently than
once every three years: Provided, That in making the
foregoing examination, the department of health shall
utilize the services of persons or organizations with
demonstrable expertise in assessing quality of health
care.

(3) Every health maintenance organization and affili-
ated provider shall submit its books and records to
such examinations and in every way facilitate them. For
the purpose of examinations, the commissioner and the
department of health shall have all powers necessary to
conduct such examinations, including, but not limited to,
the power to issue subpoenas, the power to administer
oaths to, and examine the officers and agents of the health
maintenance organization and the principles of such
providers concerning their business.

(4) The expenses of examinations under this section
shall be assessed against the organization being examined
and remitted to the commissioner.

(5) In lieu of such examination, the commissioner may
accept the report of an examination made by other states.


(1) The commissioner may suspend or revoke any
certificate of authority issued to a health maintenance
organization under this article if he finds that any of the
following conditions exist:

(a) The health maintenance organization is operating
significantly in contravention of its basic organizational
document, in any material breach of contract with an enrollee, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section three unless amendments to such submissions have been filed with an approval by the commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of premiums for health care services which do not comply with the requirements of section eight of this article;

(c) The health maintenance organization does not provide or arrange for basic health care services;

(d) The department of health certifies to the commissioner that: (i) The health maintenance organization is unable to fulfill its obligations to furnish health care services as required under its contract with enrollees; or (ii) the health maintenance organization does not meet the requirements of subsection (1), section four of this article;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under section six of this article;

(g) The health maintenance organization has failed to implement the complaint system required by section twelve of this article in a manner to reasonably resolve valid complaints;

(h) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(j) The health maintenance organization has otherwise failed to substantially comply with this article.
(2) A certificate of authority shall be suspended or revoked only after compliance with the requirements of section twenty-one of this article.

(3) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

(4) When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to terminate its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as he may find to be in the best interests of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

§33-25A-19. Rehabilitation, liquidation or conservation of health maintenance organization.

Any rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation or conservation of insurance companies. The commissioner may apply for an order directing him to rehabilitate, liquidate or conserve a health maintenance organization upon any one or more grounds set out in the vocational rehabilitation statutes or when, in his opinion, the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state.

1 The commissioner may after notice and hearing
2 promulgate reasonable rules and regulations in acor-
3 dance with chapter twenty-nine-a of this code, as are
4 necessary or proper to effectuate the purposes of this
5 article and to prevent circumvention and evasion thereof.


1 (1) When the commissioner has cause to believe that
2 grounds for the denial of an application for a certifi-
3 cate of authority exist, or that grounds for the suspension
4 or revocation of a certificate of authority exist, he shall
5 notify the health maintenance organization in writing
6 specifically stating the grounds for denial, suspension or
7 revocation and fixing a time of at least twenty days
8 thereafter for a hearing on the matter.
9 (2) After such hearing, or upon the failure of the
10 health maintenance organization to appear at such hear-
11 ing, the commissioner shall take action as is deemed
12 advisable on written findings which shall be mailed to the
13 health maintenance organization. The action of the com-
14 missioner shall be subject to review. The court may
15 modify, affirm or reverse the order of the commissioner
16 in whole or in part.
17 (3) The provisions of the administrative procedures
18 act, chapter twenty-nine-a of this code, shall apply to
19 proceedings under this article to the extent that they are
20 not in conflict with subsections (1) and (2) of this
21 section.


1 Every health maintenance organization subject to this
2 article shall pay to the commissioner the following fees:
3 For filing an application for a certificate of authority or
4 amendment thereto, one hundred dollars; and for filing
5 each annual report, ten dollars. Fees charged under this
6 section shall be deposited in the general fund of the state
7 treasury.

§33-25A-23. Penalties and enforcement.

1 (1) The commissioner may, in lieu of suspension or
2 revocation of a certificate of authority under section
nineteen of this article, levy an administrative penalty in an amount not less than one hundred dollars nor more than five thousand dollars, if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The commissioner may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.

(2) Any person who violates any provision of this article shall be guilty of a misdemeanor, and, upon conviction thereof, shall be fined not less than one thousand dollars nor more than ten thousand dollars, or imprisoned in the county jail not more than one year, or both fined and imprisoned.

(3) (a) If the commissioner shall for any reason have cause to believe that any violation of this article or regulations promulgated pursuant thereto has occurred or is threatened, prior to the levy of a penalty or suspension or revocation of a certificate of authority, the commissioner shall give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(b) Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner may deem appropriate under the circumstances. Enrollees shall be afforded notice by publication of proceedings under this subsection (3) and shall be afforded the opportunity to intervene.

(4) (a) The commissioner may issue an order directing a health maintenance organization or a representative
of a health maintenance organization to cease and desist
from engaging in any act or practice in violation of the
provisions of this article or regulations promulgated
pursuant thereto.

(b) Within ten days after service of the order of cease
and desist, the respondent may request a hearing on the
question of whether acts or practices in violation of this
article have occurred. Such hearings shall be conducted
pursuant to chapter twenty-nine-a of this code, and
judicial review shall be available as provided by chapter
twenty-nine-a of this code.

(5) In the case of any violation of the provisions of
this article or regulations promulgated pursuant thereto,
if the commissioner elects not to issue a cease and desist
order, or in the event of noncompliance with a cease and
desist order issued pursuant to subsection (4) of this
section, the commissioner may institute a proceeding to
obtain injunctive relief, or seeking other appropriate
relief, in the circuit court of the county of the principal
place of business of the health maintenance organization.

(6) Any enrollee or resident of the service area of
the health maintenance organization may bring an action
to enforce any provision, standard or regulation enforce-
able by the commissioner. In the case of any successful
action to enforce this article, or accompanying standards
or regulations, the individual shall be awarded the costs
of the action together with a reasonable attorney’s fee
as determined by the court.

§33-25A-24. Statutory construction and relationship to other
laws.

1 (1) Except as otherwise provided in this article, provi-
sions of the insurance law and provisions of hospital or
medical service corporation laws shall not be applicable to
any health maintenance organization granted a certifi-
cate of authority under this article. This provision shall
not apply to an insurer or hospital or medical service
corporation licensed and regulated pursuant to the in-
surance laws or the hospital or medical service corpora-
tion laws of this state except with respect to its health
maintenance corporation activities authorized and regulated pursuant to this article.

(2) Factually accurate advertising or solicitation regarding the range of services provided, the premiums and copayments charged, the sites of services and hours of operation, and any other quantifiable, nonprofessional aspects of its operation by a health maintenance organization granted a certificate of authority, or its representative shall not be construed to violate any provision of law relating to solicitation or advertising by health professions: Provided, That nothing contained herein shall be construed as authorizing any solicitation or advertising which identifies or refers to any individual provider, or makes any qualitative judgment concerning any provider.

(3) Any health maintenance organization authorized under this article shall not be deemed to be practicing medicine and shall be exempt from the provision of chapter thirty of this code, relating to the practice of medicine.

§33-25A-25. Filings and reports as public documents.

All applications, filings and reports required under this article shall be treated as public documents.


Any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except (1) to the extent that it may be necessary to facilitate an assessment of the quality of care delivered pursuant to section seventeen of this article or to review the complaint system pursuant to section twelve of this article; (2) upon the express written consent of the enrollee or legally authorized representative; (3) pursuant to statute or court order for the production of evidence or the discovery thereof; or (4) in the event of claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent.
A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

§33-25A-27. Authority to contract with health maintenance organizations under medicaid.

The department of welfare is hereby authorized to enter into contracts with health maintenance organizations certified and permitted to market under the laws of this state, and to furnish to recipients of medical assistance under Title XIX of the Social Security Act, 42 U.S.C. Section 1396, et. seq., health care services offered to such recipients under the Medical Assistance Plan of West Virginia.


(1) Each employer shall offer no less than once every year to every employee and dependent entitled to receive health care under an existing health benefit plan supported in whole or in part by such employer the opportunity to become enrollees in certified health maintenance organizations which have the capacity to provide basic health services in health maintenance organization service areas in which at least twenty-five such employees reside: Provided, That nothing herein shall require an employer to contribute more on behalf of an employee seeking to enroll in a health maintenance organization than would be contributed on the employee's behalf to the existing health plan.

(2) If any employees of an employer are represented by a collective bargaining representative or other employee representative designated or selected under any law of this state, the offer described in subsection (1) of this section should be made to such collective bargaining representatives or other employee representative, and only if such representative approves the offer should it be made to employees represented by such representatives.

(3) If there is more than one certified health maintenance organization which meets the requirements of sub-
section (1) of this section and such health maintenance
organizations have service areas contemporaneously
covering the same twenty-five or more employees, the
employer shall offer such employees at least one health
maintenance organization which provides health ser-
VICES primarily through staff physicians, or medical
groups, or a combination of both; and one health mainte-
nance organization which provides health services
through other means.

(4) Any employer who knowingly fails to comply with
any of the requirements of this section shall be subject
to a fine of not more than ten thousand dollars for every
thirty-day period that such violation continues.

(5) The commissioner is authorized, in addition to the
remedy provided in subsection (4) of this section, to seek
an injunction in a court of competent jurisdiction to
compel compliance with the provisions of this section.
The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

James L. Davis  
Chairman Senate Committee

Clarence C. Chambers  
Chairman House Committee

Originated in the Senate.

To take effect ninety days from passage.

J. Glenn Jr.  
Clerk of the Senate

B. Blankenship  
Clerk of the House of Delegates

Donald L. XX  
Speaker House of Delegates

The within is approved this the 25 day of April, 1977.

John D. Roby  
Governor