HB 2619

WEST VIRGINIA LEGISLATURE

REGULAR SESSION, 1995

— • —

ENROLLED

Com. Sub. for
HOUSE BILL No. 2619

(By ~~Delegate~~ Mr. Speaker, Mr. Chambers,)
& Delegate Ashley
[By Request of the Executive]

— • —

Passed March 11, 1995

In Effect 90 Days From Passage

ENROLLED

COMMITTEE SUBSTITUTE

FOR

H. B. 2619

(By Mr. Speaker, Mr. Chambers, and Delegate Ashley)
[By Request of the Executive]

[Passed March 11, 1995; in effect ninety days from passage.]

AN ACT to amend and reenact sections two, three, four, seven, eight, nine, eleven, twelve, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty-four, twenty-five and twenty-six, article twenty-five-a, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended; and to further amend said article by adding thereto three new sections, designated sections three-a, seven-a and thirty-three, all relating to insurance; health maintenance organization act; definitions; application for certificate of authority; conditions precedent to issuance of certificate of authority; issuance of certificate of authority; effect of bankruptcy proceedings; fiduciary duties of officers; approval of contracts by commissioner; provider contracts; evidence of coverage; charges for health care services; cancellation of contract by enrollee; annual report; open enrollment period; limitation on medicare and medicaid beneficiaries; grievance procedure; prohibited practices; licensing and appointment of agents; regulation of marketing; powers of insurers and hospital and medical service corporations; examinations; suspension or revocation of certificate of authority; rehabilitation, liquidation or conservation of health maintenance organization; statutory construction and relationship to other laws;

filings and reports as public documents; confidentiality of medical information; and guaranty fund plan.

Be it enacted by the Legislature of West Virginia:

That sections two, three, four, seven, eight, nine, eleven, twelve, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty-four, twenty-five and twenty-six, article twenty-five-a, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted; and that said article be further amended by adding thereto three new sections, designated sections three-a, seven-a and thirty-three, all to read as follows:

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-2. Definitions.

(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) "Capitation" means the fixed amount paid by a health maintenance organization to a health care provider under contract with the health maintenance organization in exchange for the rendering of health care services.

(3) "Commissioner" means the commissioner of insurance.

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

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

(6) "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.

(7) "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.

(8) "Enrollee", "subscriber," or "member" 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.

(9) "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.

(10) "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 the care or hospitalization, osteopathic services, home health, health education, or 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.

(11) "Health maintenance organization" or "HMO" 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 which:

(a) Receives premiums for the provision of basic health care services to enrollees on a prepaid per capita or prepaid aggregate fixed sum basis, excluding copayments;

(b) Provides physicians' services primarily (i) directly through physicians who are either employees or partners of the organization, or (ii) through arrangements with

individual physicians or one or more groups of physicians organized on a group practice or individual practice arrangement, or (iii) through some combination of paragraphs (i) and (ii) of this subdivision;

(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; and

(d) Offers services through an organized delivery system, in which a primary care physician is designated for each subscriber upon enrollment. The primary care physician is responsible for coordinating the health care of the subscriber and is responsible for referring the subscriber to other providers when necessary: *Provided*, That when dental care is provided by the health maintenance organization the dentist selected by the subscriber from the list provided by the health maintenance organization shall coordinate the covered dental care of the subscriber, as approved by the primary care physician or the health maintenance organization.

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

(13) "Individual practice arrangement " 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 the health maintenance organization and are not members of or affiliated with a medical group.

(14) "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 health maintenance organization's annual statement, the assets of the health maintenance organization are less than the sum of all of its liabilities and required reserves.

(15) "Medical group" or "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 and optometrists, as are necessary for the provision of health services for which the group is responsible: (a) a majority of the members of which are licensed to practice medicine or osteopathy; (b) who as their principal professional activity engage in the coordinated practice of their profession; (c) 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 (e) who share medical and other records and substantial portions of major equipment and professional, technical and administrative staff.

(16) "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 health maintenance organization for health services provided to an enrollee.

(17) "Primary care physician" means the general practitioner, family practitioner, obstetrician/gynecologist, pediatrician, or specialist in general internal medicine who is chosen or designated for each subscriber who will be responsible for coordinating the health care of the subscriber, including necessary referrals to other providers.

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

(19) "Uncovered expenses" means the cost of health care services that are covered by a health maintenance

organization, for which a subscriber would also be liable in the event of the insolvency of the organization.

(20) "Service area" means the county or counties approved by the commissioner within which the health maintenance organization may provide or arrange for health care services to be available to its subscribers .

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

(22) "Surplus" means the amount by which a corporation's assets exceeds 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 health maintenance organization shall not be included in surplus.

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

(24) "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 health maintenance organizations and who has no financial or employment interest in the health maintenance organization.

§33-25A-3. Application for certificate of authority.

(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 a certificate of authority through funding drives and by receiving loans and grants.

(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 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 be treated as a health maintenance organization whose certificate of authority has been revoked: *Provided,* That all health maintenance organizations in operation for at least five years are exempt from filing applications for a new certificate of authority.

(3) The commissioner may require any organization providing or arranging for health care services on a prepaid per capita or prepaid aggregate fixed sum basis to apply for a certificate of authority under this article. The commissioner shall promulgate rules to facilitate the enforcement of this subsection: *Provided,* That any provider who is assuming risk by virtue of a contract or other arrangement with an HMO or entity which has a certificate, may not be required to file for a certificate: *Provided, however,* That the commissioner may require such exempted entities to file complete financial data for a determination as to their solvency. Any organization directed to apply for a certificate of authority is 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;

(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 the officer or member of the governing body or any provider or any organization or corporation owned

or controlled by that person and the health maintenance organization and the extent and nature of any contract or financial arrangements between that person and the health maintenance organization;

(d) A 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 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 health maintenance organization on a cause of action arising in this state may be served;

(i) A statement reasonably describing the service 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) A complete biographical statement on forms prescribed by the commissioner and an independent investigation report on all of the individuals referred to in subdi-

vision (c) of this section and all officers, directors and persons holding five percent or more of the common stock of the organization;

(m) 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 health maintenance organization has been projected to be profitable for twelve consecutive months. The study must show that the health maintenance organization would not, at the end of any month of the projection period, have less than the minimum capital and surplus as required by subparagraph (ii), subdivision (c), subsection (2), section four of this article. The qualified independent actuary shall certify that: The rates are neither inadequate nor excessive nor unfairly discriminatory; the rates are appropriate for the classes of risks for which they have been computed; 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; the health maintenance organization is actuarially sound: *Provided, however,* That the certification shall consider the rates, benefits, and expenses of, and any other funds available for the payment of obligations of, the organization; the rates being charged or to be charged are actuarially adequate to the end of the period for which rates have been guaranteed; and incurred but not reported claims and claims reported but not fully paid have been adequately provided for; and

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

(5) A health maintenance 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 shall be considered approved and may be implemented by the health maintenance organization.

§33-25A-3a. Conditions precedent to issuance or maintenance of a certificate of authority; effect of bankruptcy proceedings.

(1) As a condition precedent to the issuance or maintenance of a certificate of authority, a health maintenance organization must file or have on file with the commissioner:

(a) An acknowledgment that a delinquency proceeding pursuant to article ten of this chapter or supervision by the commissioner pursuant to article thirty-four of this chapter constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization, or conservation of a health maintenance organization; and

(b) A waiver of any right to file or be subject to a bankruptcy proceeding.

(2) After the effective date of this section, as a condition precedent to the issuance of a certificate of authority, any organization that has not yet obtained a certificate of authority to operate a health maintenance organization in this state shall be incorporated under the provisions of article one, chapter thirty-one of this code.

(3) The commencement of a bankruptcy proceeding either by or against a health maintenance organization shall, by operation of law:

(a) Terminate the health maintenance organization's certificate of authority; and

(b) Vest in the commissioner for the use and benefit of the subscribers of the health maintenance organization the title to any deposits of the HMO held by the commissioner.

(4) If the proceeding is initiated by a party other than the health maintenance organization, the operation of subsection (2) of this section shall be stayed for a period of sixty days following the date of commencement of the proceeding.

§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 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 provided by the organization; 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 such other matters as may be 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 fully paid in capital stock, if a for profit stock corporation, or statutory surplus, funds, if a nonprofit corporation, at least one million dollars. In addition, each health maintenance organization shall have and maintain additional surplus funds of at least one million dollars;

(iii) Any arrangements which 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 orga-

nization from obtaining insurance or making other arrangements:

(i) For the cost of providing to any enrollee health care services, the aggregate value of which exceeds four thousand dollars 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 section seven, article eight of this chapter in the amount of one hundred thousand dollars.

(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 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.

§33-25A-7. Fiduciary responsibilities of officers; approval of contracts by commissioner.

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

(b) Any contracts made with providers of health care services enabling a health maintenance organization to provide health care services authorized under this article shall be filed with the commissioner. The commissioner has the power to require immediate cancellation of the contracts or the immediate renegotiation of the contract by the parties whenever he or she 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-7a. Provider contracts.

(1) Whenever a contract exists between a health maintenance organization and a provider and the organization fails to meet its obligations to pay fees for services already rendered to a subscriber, the health maintenance organization is liable for the fee or fees rather than the subscriber; and the contract shall state that liability.

(2) No subscriber of an HMO is liable to any provider of health care services for any services covered by the HMO if at any time during the provision of the services, the provider, or its agents, are aware the subscriber is an HMO enrollee.

(3) No provider of services or any representative of the provider shall collect or attempt to collect from an HMO subscriber any money for services covered by an HMO and no provider or representative of the provider may maintain any action at law against a subscriber of an HMO to collect money owed to the provider by an HMO.

(4) Every contract between an HMO and a provider of health care services shall be in writing and shall contain a provision that the subscriber is not liable to the provider for any services covered by the subscriber's contract with the HMO.

(5) The provisions of this section shall not be construed to apply to the amount of any deductible or copayment which is not covered by the contract of the HMO.

(6) For all provider contracts executed on or after the fifteenth day of April, one thousand nine hundred ninety-five and within one hundred eighty days of that date for contracts in existence on that date:

(a) The contracts must provide that the provider shall provide sixty days advance written notice to the health maintenance organization and the commissioner before canceling the contract with the health maintenance organization for any reason; and

(b) The contract must also provide that nonpayment for goods or services rendered by the provider to the health maintenance organization is not a valid reason for avoiding the sixty day advance notice of cancellation.

(7) Upon receipt by the health maintenance organization of a sixty day cancellation notice, the health maintenance organization may, if requested by the provider, terminate the contract in less than sixty days if the health maintenance organization is not financially impaired or

insolvent.

§33-25A-8. Evidence of coverage; charges for health care services; cancellation of contract by enrollee.

(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 grievances.

(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, is subject to the filing and approval requirements of subdivision (b),

subsection (1) 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 or medical 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 (c), subsection (1) of this section, are applicable.

(2) Premiums may be established in accordance with actuarial principles: *Provided,* That premiums shall not be excessive, inadequate, or unfairly discriminatory. A certification by a qualified independent actuary shall accompany a rate filing and, shall certify that: The rates are neither inadequate nor excessive nor unfairly discriminatory; that the rates are appropriate for the classes of risks for which they have been computed; provide an adequate description of the rating methodology showing that the methodology follows consistent and equitable actuarial principles; and the rates being charged are actuarially adequate to the end of the period for which rates have been guaranteed. In determining whether the charges are reasonable, the commissioner shall consider whether the health maintenance organization has (a) made a vigorous, good faith effort to control rates paid to health care providers; (b) established a premium schedule, including copayments, if any, which encourages enrollees to seek out preventive health care services; and (c) made a good faith effort to secure arrangements whereby basic services can be obtained by subscribers from local providers to the extent that the providers offer the services.

(3) Rates are inadequate if the premiums derived from the rating structure, plus investment income, co-payments, 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 medical and hospital benefits during the period for which the rates are to be effective, and the other expenses which would be incurred if other expenses were at the level for the current or nearest future period during which the HMO is projected to make a profit. For this analysis, investment income

shall not exceed three percent of total projected revenues.

(4) The commissioner shall within a reasonable period approve any form if the requirements of subsection (1) of this section are met and any schedule of charges if the requirements of subsection (2) 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 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 schedule of charges within sixty days of the filing of the forms or charges, they shall be considered approved.

(5) 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.

(6) An individual enrollee may cancel a contract with a health maintenance organization at any time for any reason: *Provided,* That a health maintenance organization may require that the enrollee give sixty 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 health maintenance organization pursuant to the terms of that contract.

§33-25A-9. Annual report.

(1) Every health maintenance organization shall comply with and is subject to the provisions of section fourteen, article four of this chapter relating to filing of financial statements with the commissioner and the national association of insurance commissioners. The annual financial statement required by that section shall include, but not be limited to, the following:

(a) A statutory 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 obligations arising out of the health maintenance contract; and (iii) expenditures for capital improvements, or additions thereto, including, but not limited to, construction, 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 on a form prescribed by the commissioner;

(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 and human resources or other accredited entity;

(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 those 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 or her duties under this article.

§33-25A-11. Open enrollment period; limitation on medicare and medicaid beneficiaries.

(1) Once a health maintenance organization has been in operation at least five years, or has enrollment of not

less than fifty thousand persons, the 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 the open enrollment period is equal to three percent of the health maintenance organization's net increase in enrollment during the previous year.

(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:

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

(b) Authorize the 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 waiver or authorization.

(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 permit by written order and upon application of a health maintenance organization, the health maintenance organization to exceed the fifty percent limitation,

but in no event may the medicare and medicaid beneficiaries enrollment exceed seventy-five percent of its total enrollee population: *Provided,* That before the commissioner grants such a waiver, the health maintenance organization must provide the opinion of a qualified independent actuary that the higher percentage of medicaid and medicare recipients will not be detrimental to the solvency of the health maintenance organization for a period of at least thirty-six months into the future.

§33-25A-12. Grievance procedure.

(1) A health maintenance organization shall establish and maintain a grievance procedure, which has been approved by the commissioner, to provide adequate and reasonable procedures for the expeditious resolution of written grievances initiated by enrollees concerning any matter relating to any provisions of the 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) A detailed description of the HMO's subscriber grievance procedure shall be included in all group and individual contracts as well as any certificate or member handbook provided to subscribers. This procedure shall be administered at no cost to the subscriber. An HMO subscriber grievance procedure shall include the following:

(a) Both informal and formal steps shall be available to resolve the grievance. A grievance is not considered formal until a written grievance is executed by the subscriber or completed on such forms as prescribed and received by the HMO;

(b) Each HMO shall designate at least one grievance coordinator who is responsible for the implementation of the HMO's grievance procedure;

(c) Phone numbers shall be specified by the HMO for the subscriber to call to present an informal grievance or

to contact the grievance coordinator. Each phone number shall be toll free within the subscriber's geographic area and provide reasonable access to the HMO without undue delays. There must be an adequate number of phone lines to handle incoming grievances;

(d) An address shall be included for written grievances;

(e) Each level of the grievance procedure shall have some person with problem solving authority to participate in each step of the grievance procedure;

(f) The HMO shall process the formal written subscriber grievance through all phases of the grievance procedure in a reasonable length of time not to exceed sixty days, unless the subscriber and HMO mutually agree to extend the time frame. If the complaint involves the collection of information outside the service area, the HMO has thirty additional days to process the subscriber complaint through all phases of the grievance procedure. The time limitations prescribed in this subdivision requiring completion of the grievance process within sixty days shall be tolled after the HMO has notified the subscriber, in writing, that additional information is required in order to properly complete review of the grievance. Upon receipt by the HMO of the additional information requested, the time for completion of the grievance process set forth in this subdivision shall resume.

(g) The subscriber grievance procedure shall state that the subscriber has the right to appeal to the commissioner. There shall be the additional requirement that subscribers under a group contract between the HMO and a department or division of the state shall first appeal to the state agency responsible for administering the relevant program, and if either of the two parties are not satisfied with the outcome of the appeal, they may then appeal to the commissioner. The HMO shall provide to the subscriber written notice of the right to appeal upon completion of the full grievance procedure and supply the commissioner with a copy of the final decision letter;

(h) The HMO shall have physician involvement in

reviewing medically related grievances. Physician involvement in the grievance process should not be limited to the subscriber's primary care physician, but may include at least one other physician;

(i) The HMO shall offer to meet with the subscriber during the formal grievance process. The location of the meeting shall be at the administrative offices of the HMO within the service area or at a location within the service area which is convenient to the subscriber;

(j) The HMO may not establish time limits of less than one year from the date of occurrence for the subscriber to file a formal grievance;

(k) Each HMO shall maintain an accurate record of each formal grievance. Each record shall include the following: (i) A complete description of the grievance, the subscriber's name and address, the provider's name and address and the HMO's name and address; (ii) a complete description of the HMO's factual findings and conclusions after completion of the full formal grievance procedure; (iii) a complete description of the HMO's conclusions pertaining to the grievance as well as the HMO's final disposition of the grievance; and (iv) a statement as to which levels of the grievance procedure the grievance has been processed and how many more levels of the grievance procedure are remaining before the grievance has been processed through the HMO's entire grievance procedure.

Copies of the grievances and the responses thereto shall be available to the commissioner, and the public for inspection for three years.

(3) Any subscriber grievance in which time is of the essence must be handled on an expedited basis, such that a reasonable person would believe that a prevailing subscriber would be able to realize the full benefit of a decision in his or her favor.

(4) Each health maintenance organization shall submit to the commissioner an annual report in a form prescribed

by the commissioner which describes such grievance procedure and contains a compilation and analysis of the grievances filed, their disposition, and their underlying causes.

§33-25A-14. Prohibited practices.

(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 considered 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 organization;

(b) A statement or item of information shall be considered to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, the 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 the benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist;

(c) An evidence of coverage shall be considered 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 the 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 rules 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 and the notice shall include the reasons for the cancellation or nonrenewal: *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: *Provided, however,* That 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 of a health maintenance organization who 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: *Provided,* That a health maintenance organization may petition the commissioner to exceed an enrollment of three hundred thousand persons and, upon notice and hearing, good cause being shown and a determination made that such an increase would be beneficial to the subscribers, creditors and stockholders of the organization or would otherwise increase the availability of coverage to consumers within the state, the commissioner may, by written order only, allow the petitioning organization to exceed an enrollment of three hundred thousand persons.

(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 the 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 applies 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 sixty 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 the 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.

§33-25A-15. Agent licensing and appointment required; regulation of marketing.

(1) Health maintenance organizations are subject to the provisions of article twelve of this chapter.

(2) After a subscriber signs an HMO enrollment application and before the HMO can process the application changing or initiating the subscriber coverage, each HMO must verify the intent and desire of the individual subscriber to join the HMO. The verification must be in writing and conducted by someone outside the HMO's marketing department. Each verification shall include the following:

(a) Confirmation that the subscriber intends and desires to join the HMO;

(b) If the subscriber is a medicare or medicaid recipient, confirmation that the subscriber understands by joining the HMO he or she will be limited to the benefits provided by the HMO, and medicare or medicaid will pay the HMO for the subscriber coverage;

(c) Confirmation that the subscriber understands the applicable restrictions of HMOs, especially that he or she must use the HMO providers and secure approval from the HMO to use health care providers outside the plan; and

(d) If the subscriber is a member of an HMO, confirmation that the subscriber understands he or she is transferring to another HMO.

(e) The HMO shall not pay a commission, fee, money or any other form of scheduled compensation to any health insurance agent until verification from the subscriber of his or her intent and desire to enroll into the HMO has been secured and the enrollment process has been completed. The HMO shall verify the intent of the subscriber to enroll with a written notice to the subscriber stating that he or she has transferred from his or her existing coverage (i.e. from medicare, medicaid, another HMO, etc.) to the new HMO. Each written verification notice shall be accompanied with printed materials explaining the nature of the HMO and any applicable restrictions and exclusions. The enrollment process shall be considered complete seven days after the HMO mails the confirmation notice. Each HMO must notify the subscriber of the date enrollment begins and when benefits will be available. Each HMO is directly responsible for enrollment abuses.

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

§33-25A-16. Powers of insurers and hospital and medical service corporations.

(1) An insurance company licensed in this state or a hospital or medical service corporation authorized to do business in this state, after applying for and receiving a certificate of authority as a health maintenance organization, may through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this article. Notwithstanding any other law to the contrary, any two or more 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 considered 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 the 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 providers with whom the organization has contracts, agreements or other arrangements as often as he or she considers it necessary for the protection of the interests of the people of this state but not less frequently than once every three years.

(2) The commissioner may contract with the department of health and human resources or any entity contracted with by the department of health and human resources which has been accredited by a nationally recognized accrediting organization and has been approved by the commissioner to make examinations concerning the quality of health care services of any health maintenance organization and providers with whom the organization has contracts, agreements or other arrangements as often as it considers 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 examination, the department of health and human resources or the accredited entity shall utilize the services of persons or organizations with demonstrable expertise in assessing quality of health care.

(3) Every health maintenance organization and affiliated provider shall submit its books and records to the examinations and in every way facilitate them. For the purpose of examinations, the commissioner and the department of health and human resources have all powers necessary to conduct the 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 the providers concerning their business.

(4) The health maintenance organization is subject to the provisions of section nine, article two of this chapter in regard to the expense and conduct of examinations.

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

§33-25A-18. Suspension or revocation of certificate of authority.

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

(a) The health maintenance organization is operating significantly in contravention of its basic organization 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 of this article unless amendments to the submissions have been filed with an approval of 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 and human resources or other accredited entity 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 or is otherwise determined by the Commissioner to be in a hazardous financial condition;

(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 grievance procedure required by section twelve of this article in a manner to reasonably resolve valid grievances;

(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;

(j) The health maintenance organization has otherwise failed to substantially comply with this article; or

(k) The health maintenance organization has violated a lawful order of the commissioner.

(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 the suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solici-

tation whatsoever.

(4) When the certificate of authority of a health maintenance organization is revoked, the 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 the 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 or she 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 considered to be the rehabilitation, liquidation or conservation of an insurance company, shall be the exclusive remedy for rehabilitation, liquidation and conservation of an HMO as provided by this article 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 or her to rehabilitate, liquidate or conserve a health maintenance organization upon any one or more grounds set out in the rehabilitation statutes or when, in his or her opinion, the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state.

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

(a) Except as otherwise provided in this article, provisions of the insurance laws and provisions of hospital or medical service corporation laws are not applicable to any health maintenance organization granted a certificate of authority under this article. The provisions of this article shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insur-

ance laws or the hospital or medical service corporation laws of this state except with respect to its health maintenance corporation activities authorized and regulated pursuant to this article.

(b) 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 in this subsection 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.

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

(d) The provisions of section fifteen, article four (general provisions); article six-c (guaranteed loss ratio); article seven (assets and liabilities); article eight (investments); article nine (administration of deposits); article twelve (agents, brokers, solicitors and excess line); section fourteen, article fifteen (individual accident and sickness insurance); section sixteen, article fifteen (coverage of children); section eighteen, article fifteen (equal treatment of state agency); section nineteen, article fifteen (coordination of benefits with medicaid); article fifteen-b (uniform health care administration act); section three, article sixteen (required policy provisions); section three-f, article sixteen (treatment of temporomandibular disorder and craniomandibular disorder); section eleven, article sixteen (coverage of children); section thirteen, article sixteen (equal treatment of state agency); section fourteen, article sixteen (coordination of benefits with medicaid); article sixteen-a (group health insurance conversion); article sixteen-c (small employer group policies); article sixteen-d (marketing and rate practices for small employ-

ers); article twenty-seven (insurance holding company systems); article thirty-four-a (standards and commissioner's authority for companies deemed to be in hazardous financial condition); article thirty-five (criminal sanctions for failure to report impairment); article thirty-seven (managing general agents); and article thirty-nine (disclosure of material transactions) shall be applicable to any health maintenance organization granted a certificate of authority under this article. In circumstances where the code provisions made applicable to health maintenance organizations by this section refer to the "insurer", the "corporation" or words of similar import, the language shall be construed to include health maintenance organizations.

(e) Any long-term care insurance policy delivered or issued for delivery in this state by a health maintenance organization shall comply with the provisions of article fifteen-a of this chapter.

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

All applications, filings and reports required under this article shall be treated as public documents: *Provided,* That where the provisions of other articles in this chapter are applicable to health maintenance organizations, all applications, filings and reports required under those articles shall be afforded the level of confidentiality as provided in those articles.

§33-25A-26. Confidentiality of medical information.

Any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant obtained from that 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 grievance procedure pursuant to section twelve of this article; (2) upon the express written consent of the enrollee or his or her legally authorized representative; (3) pursuant to statute or court order for the production of evidence or the discovery

thereof; (4) in the event of claim or litigation between that person and the health maintenance organization wherein the data or information is pertinent; or (5) to a department or division of the state pursuant to the terms of a group contract for the provision of health care services between the HMO and the department or division of the state. A health maintenance organization is entitled to claim any statutory privileges against the disclosure which the provider who furnished the information to the health maintenance organization is entitled to claim.

§33-25A-33. Guaranty fund.

On or before the fifteenth day of January, one thousand nine hundred ninety-six, the commissioner shall submit a report to the Legislature setting forth a plan to establish a guaranty fund for health maintenance organizations operating in West Virginia.

The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

Originating in the House.

Takes effect ninety days from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker of the House of Delegates

The within _____ this the _____

day of _____, 1995.

Governor

PRESENTED TO THE
GOVERNOR
Date 3/24/95
Time 3:59 PM