HB 2043

WEST VIRGINIA LEGISLATURE

FIRST REGULAR SESSION, 1999

ENROLLED

COMMITTEE SUBSTITUTE
FOR
House Bill No. 2043

(By Delegate Douglas)

Passed March 11, 1999

In Effect from Passage

ENROLLED

COMMITTEE SUBSTITUTE

FOR

H. B. 2043

(BY DELEGATE DOUGLAS)

[Passed March 11, 1999; in effect from passage.]

AN ACT to amend and reenact section two-a, article twelve, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended; to amend and reenact section nineteen, article fifteen of said chapter; to amend and reenact section four, article fifteen-a of said chapter; and to further amend said chapter by adding thereto a new article, designated article twenty-five-d, all relating to prepaid limited health service organizations; establishing requirements for doing business; continuing education requirements for agents; coordination with medicaid; the relationship to long-term care insurance; conditions for and revocation of certificates of authority; providing minimum capital requirements; establishing powers of a prepaid limited health service organization; providing enrollee participation; setting requirements for provider contracts; setting requirements for premiums; requiring approval of approval forms; requiring financial statements; setting grievance procedures; regulating marketing; providing for financial examinations; establishing a quality assurance program; providing for civil and

criminal penalties and enforcement; and dictating statutory construction and relationship to other laws.

Be it enacted by the Legislature of West Virginia:

That section two-a, article twelve, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted; that section nineteen, article fifteen of said chapter be amended and reenacted; that section four, article fifteen-a of said chapter be amended and reenacted; and that said chapter be further amended by adding thereto a new article, designated article twenty-five-d, all to read as follows:

ARTICLE 12. AGENTS, BROKERS, SOLICITORS AND EXCESS LINE.

§33-12-2a. Continuing education required.

(a) The purpose of this provision is to provide continuing education under guidelines set up under the insurance commissioner's office, with the guidelines to be set up under the board of insurance agent education. Nothing in this section prohibits an individual from receiving commissions which have been vested and earned while that individual maintained an approved insurance agent's license.

(b) This section applies to persons licensed to engage in the sale of the following types of insurance:

(1) Life insurance, annuity contracts, variable annuity contracts and variable life insurance;

(2) Sickness, accident and health insurance;

(3) All lines of property and casualty insurance; and

(4) All other lines of insurance for which an examination is required for licensing.

(c) This section does not apply to:

(1) Persons holding resident licenses for any kind or kinds of insurance offered in connection with loans or other credit transactions or insurance for which an examination is not required by the commissioner, nor does it apply to any limited or restricted license as the commissioner may exempt;

(2) Individuals selling credit life or credit accident and health insurance.

(d) (1) The board of insurance agent education as established by section two of this article shall develop a program of continuing insurance education and submit the proposal for the approval of the commissioner on or before the thirty-first day of December of each year. The program shall contain a requirement that any person appointed to be an agent on behalf of a licensed health maintenance organization or prepaid limited health service organization at any time during the relevant biennium shall, as a component of his or her mandatory continuing insurance education, complete a minimum of six hours of continuing insurance education during the biennium which is on topics specific to managed care organizations.

No program may be approved by the commissioner that includes a requirement that any agent complete more than thirty hours of continuing insurance education biennially. No program may be approved by the commissioner that includes a requirement that any of the following individuals complete more than six hours of continuing insurance education biennially:

(A) Insurance agents who sell only preneed burial insurance contracts; and

(B) Insurance agents who engage solely in telemarketing insurance products by a scripted presentation which scripted presentation has been filed with and approved by the commissioner.

(2) The commissioner and the board, under standards established by the board, may approve any course or program of instruction developed or sponsored by an authorized insurer, accredited college or university, agents' association, insurance trade association or independent program of instruction that presents the criteria and the number of hours that the board and commissioner determine appropriate for the purpose of this section.

(e) Persons licensed to sell insurance and who are not otherwise exempt shall satisfactorily complete the courses or programs of instructions the commissioner may prescribe.

(f) Every person, subject to the continuing education requirements shall furnish, at intervals and on forms as may be prescribed by the commissioner, written certification listing the courses, programs or seminars of instruction successfully completed by the person. The certification shall be executed by, or on behalf of, the organization sponsoring the courses, programs or seminars of instruction.

(g) Any person, failing to meet the requirements mandated in this section, and who has not been granted an extension of time, with respect to such requirements, or who has submitted to the commissioner a false or fraudulent certificate of compliance shall have his or her license automatically suspended and no further license may be issued to the person for any kind or kinds of insurance until such time as the person demonstrates to the satisfaction of the commissioner that he or she has complied with all of the requirements mandated by this section and all other applicable laws or rules.

(h) The commissioner shall notify the person of his or her suspension pursuant to subsection (g) of this section by certified mail, return receipt requested, to the last address on file with the commissioner pursuant to section twenty-nine of this article. Any person who has had a suspension order entered against him or her pursuant to this section may, within thirty calender days of receipt of the order, file with the commissioner a request for a hearing for reconsideration of the matter.

(i) Any person who does not satisfactorily demonstrate compliance with this section and all other laws applicable thereto as of the last day of the biennium following his or her suspension shall have his or her license automatically canceled and is subject to the education and examination requirements of section two of this article.

(j) The commissioner is authorized to hire personnel and make reasonable expenditures as deemed necessary for purposes of establishing and maintaining a system of continuing education for insurers.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-19. Coordination of benefits with medicaid.

Any health insurer, health maintenance organization as defined in article twenty-five-a of this chapter, prepaid limited health service organization as defined in article twenty-five-d of this chapter or hospital and medical service corporations as defined in article twenty-four of this chapter is prohibited from considering the availability or eligibility for medical assistance in this or any other state under 42 U.S.C. §1396a, Section 1902 of the Social Security Act, referred to in this article as medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders or certificateholders.

ARTICLE 15A. WEST VIRGINIA LONG-TERM CARE INSURANCE ACT.

§33-15A-4. Definitions.

(a) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide benefits for not less than twenty-four consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual policies or riders whether issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations, prepaid limited health service organizations or any similar organization. Any insurance policy which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage which also contains long-term care insurance benefits for at least six months shall comply with the provisions of this article.

(b) "Applicant" means:

(1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

(2) In the case of a group long-term care insurance policy, the proposed certificate holder.

(c) "Certificate" means, for the purposes of this article, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(d) "Commissioner" means the insurance commissioner of this state.

(e) "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

(1) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or

(2) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if the association:

(A) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(B) Has been maintained in good faith for purposes other than obtaining insurance; or

(3) An association or a trust or the trustee or trustees of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering the policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations have at the outset a minimum of one

hundred persons and have been organized and maintained in good faith for the purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws which provide that:

(A) The association or associations hold regular meetings not less than annually to further purposes of the members;

(B) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(C) The members have voting privileges and representation on the governing board and committees.

Thirty days after the filing the association or associations will be deemed to satisfy such organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(4) A group other than as described in subdivisions (1), (2) and (3), subsection (e) of this section, subject to a finding by the commissioner that:

(A) The issuance of the group policy is not contrary to the best interest of the public;

(B) The issuance of the group policy would result in economies of acquisition or administration;

(C) The benefits are reasonable in relation to the premiums charged.

(f) "Policy" means, for the purposes of this article, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization, prepaid limited health service organization or any similar organization.

ARTICLE 25D. PREPAID LIMITED HEALTH SERVICE ORGANIZATION ACT.

§33-25D-1. Short title.

This article may be cited as the "Prepaid Limited Health Service Organization Act."

§33-25D-2. Definitions.

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

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

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

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

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

(f) "Employee" means a person in some official employment or position working for a salary or wage continuously for no less than one calendar quarter and who is in such a relation to another person that the latter may control the work of the former and direct the manner in which the work is done.

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

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

(i) "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee setting out the coverage and other rights to which the enrollee is entitled.

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

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

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

(3) Who pool their income for practice as members of the group and distribute it among themselves according to a prearranged salary, drawing account or other plan; and

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

(k) "Impaired" means a financial situation in which, based upon the financial information which would be required by this chapter for the preparation of the prepaid limited health service organization's annual statement, the assets of the prepaid limited health service organization are less than the sum of all

of its liabilities and required reserves including any minimum capital and surplus required of the prepaid limited health service organization by this chapter so as to maintain its authority to transact the kinds of business or insurance it is authorized to transact.

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

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

(n) "Limited health service" means mental or behavioral health services (including mental illness, mental retardation, developmental disabilities, substance abuse, and chemical dependency), together with any services or goods included in the furnishing to any individual of a limited health service. "Limited health service" does not include inpatient services, hospital surgical services or emergency services except as such services are provided incident to and directly related to a limited health service set forth in this subsection.

(o) "Premium" means a prepaid per capita or prepaid aggregate fixed sum unrelated to the actual or potential utilization of services of any particular person which is charged by the prepaid limited health service organization for health services provided to an enrollee.

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

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

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

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

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

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

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

(4) Offers services through an organized delivery system, in which a coordinating provider of a limited health service is designated for each subscriber to that limited health service.

Prepaid limited health service organization does not include an entity otherwise authorized pursuant to the laws of this state to indemnify for any limited health service, or a provider or entity when providing a limited health service pursuant to a contract with a prepaid limited health service organization, a health maintenance organization, a health insurer or a self-insurance plan.

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

(r) "Qualified independent actuary" means an actuary who is a member of the American academy of actuaries or the

society of actuaries and has experience in establishing rates for prepaid limited health service organizations and who has no financial or employment interest in the prepaid limited health service organization.

(s) "Quality assurance" means an ongoing program designed to objectively and systematically monitor and evaluate the quality and appropriateness of the enrollee's care, pursue opportunities to improve the enrollee's care, and resolve identified problems at the prevailing professional standard of care.

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

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

(v) "Surplus" means the amount by which a corporation's assets exceed its liabilities and required reserves based upon the financial information which would be required by this chapter for the preparation of the corporation's annual statement except that assets pledged to secure debts not reflected on the books of the prepaid limited health service organization shall not be included in surplus.

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

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

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

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

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

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

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

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

(1) The basic organizational document;

(2) The bylaws or rules;

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

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

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

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

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

(B) A schedule of proposed charges; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§33-25D-4. Conditions precedent to issuance or maintenance of a certificate of authority; renewal of certificate of authority; effect of bankruptcy proceedings.

(a) As a condition precedent to the issuance or maintenance of a certificate of authority, a prepaid limited health service organization shall file or have on file with the commissioner:

(1) 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 is the sole and exclusive method for the liquidation, rehabilitation, reorganization, or conservation of a prepaid limited health service organization;

(2) A waiver of any right to file or be subject to a bankruptcy proceeding;

(3) Within thirty days of any change in the membership of the governing body of the organization or in the officers or persons holding five percent or more of the common stock of the organization, or as otherwise required by the commissioner:

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

(B) A complete biographical statement on forms prescribed by the commissioner and an independent investigation report on each such person for whom a biographical statement and independent investigation report have not previously been submitted.

(b) All certificates of authority issued to prepaid limited health service organizations expire at midnight on the thirty-first day of May of each year. The commissioner shall renew annually the certificates of authority of all prepaid limited health service organizations which continue to meet all requirements of this section and subsection (b), section five of this article, make application therefor upon a form prescribed by the commissioner and pay the renewal fee prescribed: *Provided,*

That a prepaid limited health service organization does not qualify for renewal of its certificate of authority if the organization has no subscribers in this state within twelve months after issuance of the certificate of authority: *Provided, however,* That an organization not qualifying for renewal may apply for a new certificate of authority under section three of this article.

(c) The commencement of a bankruptcy proceeding either by or against a prepaid limited health service organization, by operation of law:

(1) Terminates the prepaid limited health service organization's certificate of authority; and

(2) Vests in the commissioner for the use and benefit of the subscribers of the prepaid limited health service organization the title to any deposits of the prepaid limited health service organization held by the commissioner.

(d) If the bankruptcy proceeding is initiated by a party other than the prepaid limited health service organization, the operation of subsection (c) of this section is stayed for a period of sixty days following the date of commencement of the proceeding.

§33-25D-5. Issuance of certificate of authority.

(a) 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 limited health services to be furnished has demonstrated:

(1) The willingness and potential ability of the organization to assure that limited health services will be provided in such a manner as to enhance and assure both the availability and accessibility of adequate personnel and facilities;

(2) Arrangements for an ongoing evaluation of the quality of health care provided by the organization and utilization review which meet the minimum standards set forth in section nineteen of this article;

(3) 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 other matters as may be reasonably required by rule.

(b) 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:

(1) The prepaid limited health service organization's proposed plan of operation meets the requirements of subsection (a) of this section;

(2) The prepaid limited health service organization will effectively provide or arrange for the provision of no more than four limited health services on a prepaid basis except for copayments: *Provided,* That nothing in this section relieves a prepaid limited health service organization from the obligations to provide a limited health service 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 permits a prepaid limited health service organization to charge copayments to medicare beneficiaries or medicaid recipients in excess of the copayments permitted under those programs, nor is a prepaid limited health service organization required to provide a limited health service to medicare beneficiaries or medicaid recipients in excess of the benefits compensated under those programs;

(3) The prepaid limited health service 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:

(A) The financial soundness of the prepaid limited health service organization's arrangements for no more than four limited health services and the proposed schedule of charges used in connection with each limited health service offered;

(B) Arrangements for maintenance of the minimum capital and surplus required under section six of this article;

(C) Any arrangements which will guarantee 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

(D) Any agreement with providers for the provision of limited health care services;

(4) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to section eight of this article;

(5) The prepaid limited health service organization has demonstrated that it will assume full financial risk on a prospective basis for the provision of no more than four limited health services: *Provided,* That notwithstanding the requirement of this subdivision, a prepaid limited health service organization may obtain reinsurance acceptable to the commissioner from an accredited reinsurer or make other arrangements:

(A) For the cost of providing to any enrollee limited health services, the aggregate value of which exceeds four thousand dollars in any year;

(B) For the cost of providing no more than four limited health services to its enrollees on a nonelective emergency basis; or

(C) For not more than ninety-five percent of the amount by which the prepaid limited health service organization's costs for any of its fiscal years exceed one hundred five percent of its income for those fiscal years;

(6) The ownership, control and management of the prepaid limited health service organization is competent and trustworthy and possesses managerial experience that would make the proposed 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 prepaid

limited health service 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; and

(7) The prepaid limited health service 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 fifty thousand dollars.

(c) A certificate of authority may be denied only after compliance with the requirements of section twenty-three of this article.

(d) No person who has not been issued a certificate of authority may use the words "prepaid limited health service organization" or the initials "PLHSO" in its name, contracts, logo or literature: *Provided,* That persons who are operating under a contract with, operating in association with, enrolling enrollees for, or otherwise authorized by a prepaid limited health service organization licensed under this article to act on its behalf may use the terms "prepaid limited health service organization" or "PLHSO" for the limited purpose of denoting or explaining their association or relationship with the authorized prepaid limited health service organization. No prepaid limited health service organization which has a minority of board members who are consumers may use the words "consumer controlled" in its name or in any way represent to the public that it is controlled by consumers.

§33-25D-6. Minimum capital.

(a) Each prepaid limited health service organization shall have and maintain fully paid-in capital stock, if a for-profit stock corporation, or statutory surplus funds, if a nonprofit corporation, totaling at least:

(1) The greater of two hundred fifty thousand dollars or ten percent of its expenses for the previous twelve-month period as reported in its most recent financial statement filed pursuant to subsection (a), section twelve of this article, with respect to each limited health service for which the organization will not offer inpatient services up to a maximum total for all limited health services of the required capital and surplus for an insurer under article three, section five-b of this chapter; and

(2) The greater of one million dollars or ten percent of its expenses for the previous twelve-month period as reported in its most recent financial statement filed pursuant to subsection (a), section twelve of this article, with respect to each limited health service for which the organization will offer inpatient services up to a maximum total for all limited health services of the required capital and surplus for an insurer under article three, section five-b of this chapter.

(b) For purposes of this section, "expenses" means those costs set forth by the national association of insurance commissioners (NAIC) in the statement of revenues, expenses and net worth contained in the annual statement instruction—limited health service organization and the official NAIC annual statement blanks—limited health service organization.

§33-25D-7. Powers of organization.

(a) Upon obtaining a certificate of authority as required under this article, a prepaid limited health service organization may enter into limited health service 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: *Provided,* That nothing in this article authorizes any prepaid limited health service organization to transact any insurance other than that for which the organization is granted a certificate of authority under this article.

(b) The commissioner may propose rules for legislative approval in accordance with the provisions of article three,

chapter twenty-nine-a of this code, limiting or regulating the powers of prepaid limited health service organizations which he or she finds to be in the public interest.

§33-25D-8. Governing body; enrollee participation.

(a) The governing body of any prepaid limited health service organization may include enrollees, providers, or other individuals.

(b) The 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 major policy decisions, or through the use of other mechanisms as may be prescribed by the commissioner.

§33-25D-9. Fiduciary responsibilities of managers; fidelity bond.

(a) Any director, officer or other manager of a prepaid limited health service 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) A prepaid limited health service organization shall maintain a blanket fidelity bond covering all directors, officers, managers and employees of the organization who receive, collect, disburse or invest funds in connection with the activities of the organization, issued by an insurer licensed in this state or, if the fidelity bond required by this subdivision is not available from an insurer licensed in this state, a fidelity bond procured by an excess line broker licensed in this state, in an amount at least equal to the minimum amount of fidelity insurance as provided in the national association of insurance commissioners handbook, as amended, or as the commissioner may by rule, propose for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code, require.

§33-25D-10. Provider contracts.

(a) A prepaid limited health service organization shall file with the commissioner any contracts made with providers of a

limited health service, enabling the prepaid limited health service organization to provide limited health services authorized under this article. The commissioner may require the immediate cancellation of a contract or the immediate renegotiation of a contract by the parties if he or she determines that a contract provides for excessive payments, fails to include reasonable incentives for cost control, or otherwise substantially and unreasonably contributes to escalation of the costs of providing a limited health service to enrollees.

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

(c) No enrollee of a prepaid limited health service organization is liable to any provider of a limited health service for any service covered by the prepaid limited health service organization if at any time during the provision of the service, the provider or its agents are aware the individual to whom the service is provided is an enrollee of a prepaid limited health service organization.

(d) If at any time during the provision of a limited health service, a provider or its agents are aware that the subscriber is a prepaid limited health service organization enrollee for the service provided, the provider of services or any agent or representative of the provider may not collect or attempt to collect from a subscriber any money for services covered by a prepaid limited health service organization, and no provider or agent or representative of the provider may maintain any action at law against a subscriber of a prepaid limited health service organization to collect money owed to the provider by a prepaid limited health service organization.

(e) Every contract between a prepaid limited health service organization and a provider of a limited health service shall be in writing and shall contain a provision that the subscriber is not liable to the provider for any services covered by the sub-

scriber's contract with the prepaid limited health service organization.

(f) The provisions of this section do not apply to the amount of any deductible or copayment not payable by the prepaid limited health service organization pursuant to its contract with its subscriber.

(g) When a subscriber receives covered emergency health care services from a noncontracting provider, the prepaid limited health service organization is responsible for payment of the provider's normal charges for the health care services, exclusive of any applicable deductibles or copayments.

(h) For all provider contracts executed on or after the effective date of this article and within one hundred eighty days of that date for contracts in existence on that date:

(1) The contracts shall provide that the provider provide sixty days advance written notice to the prepaid limited health service organization and the commissioner before canceling the contract with the prepaid limited health service organization for any reason; and

(2) The contract shall provide that nonpayment for goods or services rendered by the provider to the prepaid limited health service organization is not a valid reason for avoiding the sixty-day advance notice of cancellation.

(i) Upon receipt by the prepaid limited health service organization of a sixty-day cancellation notice, the prepaid limited health service organization may, if requested by the provider, terminate the contract in less than sixty days if the prepaid limited health service organization is not financially impaired or insolvent.

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

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

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

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

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

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

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

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

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

(F) The following exact statement in bold print:

"Each subscriber or enrollee, by acceptance of the benefits described in this evidence of coverage, consents to the examination of his or her medical records for purposes of utilization

review, quality assurance and peer review by the prepaid limited health service organization or its designee."

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

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

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

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

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

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

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

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

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

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

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

(c) Rates for a particular limited health service are inadequate if the premiums derived from the rating structure, plus investment income, copayments, and revenues from coordination of benefits and subrogation, fees-for-service and reinsurance recoveries are not set at a level at least equal to the anticipated cost of benefits for the limited health service during the period for which the rates are to be effective and the other expenses which would be incurred if other expenses were at the level for the current or nearest future period during which the prepaid limited health service organization is projected to make a profit. For this analysis, total investment income added to premiums, copayments and revenues from coordination of benefits and subrogation, fees-for-service and reinsurance recoveries with respect to all limited health services offered may not exceed three percent of the prepaid limited health service organization's total projected revenues.

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

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

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

§33-25D-12. Annual and quarterly reports.

(a) Every prepaid limited health service 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:

(1) 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:

(A) All prepayment and other payments received for limited health services rendered;

(B) 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 limited health service contract;

(C) Expenditures for capital improvements, or additions thereto, including, but not limited to, construction, renovation or purchase of facilities and capital equipment; and

(D) The organization's fidelity bond;

(2) 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;

(3) A summary of information compiled pursuant to subdivision (3), subsection (a), section five of this article in such form as the commissioner requires;

(4) A report of the names and residence addresses of all persons set forth in subdivision (3), subsection (d), section three of this article who were associated with the prepaid limited health service organization during the preceding year, and the amount of wages, expense reimbursements, or other payments to those individuals for services to the prepaid limited health service organization, including a full disclosure of all financial arrangements during the preceding year required to be disclosed pursuant to subdivision (3), subsection (d), section three of this article; and

(5) Other information relating to the performance of the prepaid limited health service organization as is reasonably necessary to enable the commissioner to carry out his or her duties under this article.

§33-25D-13. Annual report to enrollees.

Every prepaid limited health service organization or its representative shall annually, before the first day of April, provide to each enrollee a summary of: Its most recent annual financial statement, including a balance sheet and statement of receipts and disbursements; a description of the prepaid limited health service organization, each limited health service offered, its facilities and personnel for each limited health service offered, any material changes therein since the last report, the current evidence of coverage for each limited health service for which the enrollee is enrolled, and a clear and understandable description of the prepaid limited health service organization's method for resolving enrollee complaints: *Provided,* That with respect to enrollees who have been enrolled through contracts between a prepaid limited health service organization and an

employer, the prepaid limited health service organization satisfies the requirement of this section by providing the requisite summary to each enrolled employee: *Provided, however,* That with respect to medicaid recipients enrolled under a group contract between a prepaid limited health service organization and the governmental agency responsible for administering the medicaid program, the prepaid limited health service organization satisfies the requirement of this section by providing the requisite summary to each local office of the governmental agency responsible for administering the medicaid program for inspection by enrollees of the prepaid limited health service organization.

§33-25D-14. Grievance procedure.

(a) A prepaid limited health service 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 limited health service 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.

(b) A detailed description of the prepaid limited health service organization'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. A prepaid limited health service organization subscriber grievance procedure shall include the following:

(1) 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 forms prescribed and received by the prepaid limited health service organization;

(2) Each prepaid limited health service organization shall designate at least one grievance coordinator who is responsible for the implementation of the prepaid limited health service organization's grievance procedure;

(3) Phone numbers shall be specified by the prepaid limited health service organization 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 prepaid limited health service organization without undue delays. There shall be an adequate number of phone lines to handle incoming grievances;

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

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

(6) The prepaid limited health service organization shall process the formal written subscriber grievance through all phases of the grievance procedure in a reasonable length of time not to exceed forty-five days, unless the subscriber and prepaid limited health service organization mutually agree to extend the time frame. If the complaint involves the collection of information outside the service area, the prepaid limited health service organization 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 are tolled after the prepaid limited health service organization has notified the subscriber, in writing, that additional information is required in order to properly complete review of the grievance. Upon receipt by the prepaid limited health service organization of the additional information requested, the time for completion of the grievance process set forth in this subdivision resumes;

(7) The subscriber grievance procedure shall state that the subscriber has the right to appeal to the commissioner within thirty days of receipt by the subscriber of a written ruling by the

prepaid limited health service organization which denies, in whole or in part, relief requested by the subscriber in a formal written subscriber grievance. There shall be the additional requirement that subscribers under a group contract between the prepaid limited health service organization and a department or division of the state shall first appeal to the state agency responsible for administering the relevant program, and if either party is not satisfied with the outcome of the appeal, the unsatisfied party may appeal to the commissioner. The prepaid limited health service organization shall provide the subscriber a 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. A subscriber has thirty days after receipt of the written notice to appeal to the commissioner if the prepaid limited health service organization's ruling denies the relief requested by the subscriber, in whole or in part;

(8) The prepaid limited health service organization shall have provider involvement in reviewing grievances related to a provider's services. Provider involvement in the grievance process may not be limited to the subscriber's coordinating provider, but shall include at least one other provider;

(9) The prepaid limited health service organization 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 prepaid limited health service organization within the service area or at a location within the service area which is convenient to the subscriber;

(10) The prepaid limited health service organization may not establish time limits of less than one year from the date of occurrence for the subscriber to file a formal grievance. The date of occurrence is the date upon which a claim, service or other matter sought by the subscriber was denied by the prepaid limited health service organization or date of occurrence of the event which gave rise to the grievance;

(11) Each prepaid limited health service organization shall maintain an accurate record of each formal grievance. Each record shall include the following:

(A) A complete description of the grievance, the subscriber's name and address, the provider's name and address and the prepaid limited health service organization's name and address;

(B) A complete description of the prepaid limited health service organization's factual findings and conclusions after completion of the full formal grievance procedure;

(C) A complete description of the prepaid limited health service organization's conclusions pertaining to the grievance as well as the prepaid limited health service organization's final disposition of the grievance; and

(D) 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 prepaid limited health service organization's entire grievance procedure.

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

(c) Any subscriber grievance in which time is of the essence shall be handled on an expedited basis, so 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.

(d) Each prepaid limited health service organization shall submit to the commissioner an annual report in a form prescribed by the commissioner which describes the grievance procedure and contains a compilation and analysis of the grievances filed, their disposition, and their underlying causes.

§33-25D-15. Prohibited practices.

(a) No prepaid limited health service 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. No advertising may be used until it has been

approved by the commissioner. Advertising which has not been disapproved by the commissioner within sixty days of filing is considered approved. For purposes of this article:

(1) A statement or item of information is 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 prepaid limited health service organization;

(2) A statement or item of information is 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 prepaid limited health service organization, if the benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist;

(3) An evidence of coverage is deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, causes a reasonable person, not possessing special knowledge regarding prepaid limited health service organizations, and evidences of coverage therefor, to expect benefits, services or other advantages which the evidence of coverage does not provide or which the prepaid limited health service organization issuing the evidence of coverage does not regularly make available for enrollees covered under the evidence of coverage; and

(4) The commissioner may further define practices which are untrue, misleading or deceptive.

(b)(1) No prepaid limited health service 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 prepaid limited health service 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.

(2) No prepaid limited health service organization may 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 prepaid limited health service organization on an individual basis. A prepaid limited health service 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.

(c)(1) No prepaid limited health service organization may use in its name, contracts, logo 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 prepaid limited health service organization has contracted with another insurer for any coverage permitted by this article, it may so state; and

(2) No person who has not been issued a certificate of authority under this article may use the words "prepaid limited health service organization" or the initials "PLHSO" in its name, contracts, logo or literature to imply, directly or indirectly, that it is a prepaid limited health service organization or hold itself out to be a prepaid limited health service organization.

(d) The providers of a prepaid limited health service organization who provide limited health services and the prepaid limited health service organization do 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.

(e) No prepaid limited health service organization may 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, are not considered discrimination in enrollment policies.

(f) (1) No agent of a prepaid limited health service organization or person selling enrollments in a prepaid limited health service organization may sell an enrollment in a prepaid limited health service organization unless the agent or person first discloses 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 and inpatient facilities, if any, associated with the prepaid limited health service organization.

(2) In any home solicitation, any three-day cooling-off period applicable to consumer transactions generally applies in the same manner as consumer transactions.

(3) The form disclosure statement may not be used in sales until it has been approved by the commissioner. 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 prepaid limited health service organization, plus costs and a reasonable attorney's fee.

(g) No contract with an enrollee may 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 prepaid limited health service organization.

(h) No contract with an enrollee may contain any provision purporting to make any portion of the articles of incorporation, charter, bylaws or other organizational document of the prepaid limited health service organization a part of the contract unless the provision is set forth in full in the contract.

(i) 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.

§33-25D-16. Agent licensing and appointment required; regulation of marketing.

(a) Prepaid limited health service organizations are subject to the provisions of article twelve of this chapter.

(b) With respect to individual or group contracts covering fewer than twenty-five subscribers, after a subscriber signs a prepaid limited health service organization enrollment application and before the prepaid limited health service organization may process the application changing or initiating the subscriber coverage, each prepaid limited health service organization shall verify in writing, in a form prescribed by the commissioner, the intent and desire of the individual subscriber to join the prepaid limited health service organization. The verification shall be conducted by someone outside the prepaid limited health service organization's marketing department and shall show that:

(1) The subscriber intends and desires to join the prepaid limited health service organization;

(2) If the subscriber is a medicare or medicaid recipient, the subscriber understands that by joining the prepaid limited

health service organization he or she will be limited to the benefits provided by the prepaid limited health service organization, and medicare or medicaid will pay the prepaid limited health service organization for the subscriber coverage;

(3) The subscriber understands the applicable restrictions of prepaid limited health service organizations, especially that he or she must use the prepaid limited health service organization providers and secure approval from the prepaid limited health service organization to use health care providers outside the plan; and

(4) If the subscriber is a member of a prepaid limited health service organization, the subscriber understands that he or she is transferring to another prepaid limited health service organization.

(c) The prepaid limited health service organization may not pay a commission, fee, money or any other form of scheduled compensation to any health insurance agent until the subscriber's application has been processed and the prepaid limited health service organization has confirmed the subscriber's enrollment by written notice in the form prescribed by the commissioner. The confirmation notice shall be accompanied by the evidence of coverage required by section eleven of this article and shall confirm:

(1) The subscriber's transfer from his or her existing coverage, such as from medicare, medicaid, another prepaid limited health service organization, etc., to the new prepaid limited health service organization; and

(2) The date enrollment begins and when benefits will be available.

(d) The enrollment process is considered complete seven days after the prepaid limited health service organization mails the confirmation notice and evidence of coverage to the subscriber. Each prepaid limited health service organization is directly responsible for enrollment abuses.

(e) The commissioner may propose rules for legislative approval in accordance with the provisions of article three,

chapter twenty-nine-a of this code, to regulate marketing of prepaid limited health service organizations by persons compensated directly or indirectly by the prepaid limited health service organization. The rules may prohibit door-to-door solicitations, may prohibit commission sales, and may provide for other proscriptions required to effectuate the purposes of this article.

§33-25D-17. Powers of insurers, hospital service corporations, medical service corporations, dental service corporations, health service corporations and health maintenance organizations.

(a) An insurance company licensed in this state, a hospital, medical, dental or health service corporation authorized to do business in this state or a health maintenance organization holding a certificate of authority under article twenty-five-a of this article, after applying for and receiving a certificate of authority as a prepaid limited health service organization, may through a subsidiary or affiliate organize and operate a prepaid limited health service organization under the provisions of this article. Notwithstanding any other law to the contrary, any two or more insurance companies, hospital, medical, dental or health service corporations, health maintenance organizations or subsidiaries or affiliates thereof, may jointly organize and operate a prepaid limited health service organization. The business of insurance is considered to include the providing of health care by a prepaid limited health service organization owned or operated by an insurer or a subsidiary of the insurer.

(b) Notwithstanding any provision of insurance, hospital, medical, dental or health service corporation or health maintenance organization laws, an insurer, a hospital, medical, dental or health service corporation or a health maintenance organization may contract with a prepaid limited health service organization to provide insurance or similar protection against the cost of care provided through prepaid limited health service organizations and to provide coverage in the event of the failure of the prepaid limited health service organization to meet its obligations. The enrollees of a prepaid limited health service organi-

zation constitute a permissible group under those laws. Under the contracts, the insurer or hospital, medical, dental or health service corporation or health maintenance organization may make benefit payments to prepaid limited health service organizations for limited health services rendered by providers.

(c) Notwithstanding any provision of insurance, hospital, medical, dental or health service corporation or health maintenance organization laws, an insurer, a hospital, medical, dental or health service corporation or a health maintenance organization may exclude in any contract or policy issued to a group, any coverage which would duplicate the coverage of a prepaid limited health service organization, whether for services, supplies or reimbursement, to the extent that the coverage or service is provided in accordance with this chapter pursuant to a contract or policy issued to the same group or to a part of that group by a prepaid limited health service organization.

§33-25D-18. Examinations.

(a) The commissioner may make an examination of the affairs of any prepaid limited health service 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.

(b) The commissioner may contract with the department of health and human resources, any entity 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 prepaid limited health service organization and providers with whom the organization has contracts, agreements or other arrangements, or any such entity contracted with by the department of health and human resources, 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.

(c) Every prepaid limited health service 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 prepaid limited health service organization and the principals of the providers concerning their business.

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

(e) In lieu of the examination, the commissioner may accept the report of an examination made by another state.

(f) The expenses of an examination assessing quality of health care under subsection (b) of this section and section nineteen of this article shall be reimbursed pursuant to subdivision (5), subsection (i), section nine, article two of this chapter.

§33-25D-19. Quality assurance.

(a) Each prepaid limited health service organization shall have in writing a quality assurance program approved by the commissioner which describes the program's objectives, organization and problem solving activities.

(b) The scope of the quality assurance program shall include, at a minimum:

(1) Organizational arrangements and responsibilities for quality management and improvement processes;

(2) A documented utilization management program;

(3) Written policies and procedures for credentialing and recredentialing physicians and other licensed providers who fall under the scope of authority of the prepaid limited health service organization;

(4) A written policy that addresses enrollees' rights and responsibilities;

(5) The adoption of practice guidelines for the use of preventive health services; and

(6) Any other criteria considered necessary by the commissioner.

(c) This section becomes effective on the first day of May, one thousand nine hundred ninety-nine.

§33-25D-20. Suspension or revocation of certificate of authority.

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

(1) The prepaid limited health service 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 of this article unless amendments to the submissions have been filed with an approval of the commissioner;

(2) The prepaid limited health service organization issues an evidence of coverage or uses a schedule of premiums limited health services which do not comply with the requirements of section eleven of this article;

(3) The prepaid limited health service organization does not provide or arrange for those limited health services which it has contracted to provide to enrollees;

(4) The department of health and human resources or other accredited entity certifies to the commissioner that:

(A) The prepaid limited health service organization is unable to fulfill its obligations to furnish limited health services as required under its contract with enrollees; or

(B) The prepaid limited health service organization does not meet the requirements of subsection (a), section five of this article;

(5) The prepaid limited health service 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;

(6) The prepaid limited health service organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under section eight of this article;

(7) The prepaid limited health service organization has failed to implement the grievance procedure required by section fourteen of this article in a manner to reasonably resolve valid grievances;

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

(9) The continued operation of the prepaid limited health service organization would be hazardous to its enrollees;

(10) The prepaid limited health service organization has otherwise failed to substantially comply with this article;

(11) The prepaid limited health service organization has violated a lawful order of the commissioner; or

(12) The prepaid limited health service organization has failed to implement or maintain a quality assurance program considered satisfactory by the commissioner which meets the minimum standards set forth in section nineteen of this article.

(b) A certificate of authority may be suspended or revoked only after compliance with the requirements of section twenty-three of this article.

(c) When the certificate of authority of a prepaid limited health service organization is suspended, the prepaid limited health service organization may not, during the period of the suspension, enroll any additional enrollees except newborn

children or other newly acquired dependents of existing enrollees, and may not engage in any advertising or solicitation.

(d) When the certificate of authority of a prepaid limited health service organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to terminate its affairs, and may conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It may engage in no further advertising or solicitation. The commissioner may, by written order, permit 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 limited health service coverage.

§33-25D-21. Rehabilitation, liquidation or conservation of prepaid limited health service organization.

Any rehabilitation, liquidation or conservation of a prepaid limited health service organization is considered to be the rehabilitation, liquidation or conservation of an insurance company, is the exclusive remedy for rehabilitation, liquidation and conservation of a prepaid limited health service organization 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 prepaid limited health service 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 prepaid limited health service organization would be hazardous either to the enrollees or to the people of this state.

§33-25D-22. Rules.

The commissioner may propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code:

(1) To effectuate the purposes of this article and to prevent circumvention and evasion thereof; and

(2) To define the commissioner's authority to consider the operating results of a prepaid limited health service organization's affiliates and subsidiaries in the rate making and solvency determination of that prepaid limited health service organization.

§33-25D-23. Administrative procedures.

(a) When the commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, he or she shall notify the prepaid limited health service organization in writing specifically stating the grounds for denial, suspension or revocation and fixing a time of at least twenty days thereafter for a hearing on the matter.

(b) After the hearing, or upon the failure of the prepaid limited health service organization to appear at the hearing, the commissioner shall take action as is considered advisable on written findings which shall be mailed to the prepaid limited health service organization. The action of the commissioner is subject to review. The court may modify, affirm or reverse the order of the commissioner, in whole or in part.

(c) Proceedings under this article are governed by the provisions of section thirteen, article two of this chapter.

§33-25D-24. Fees.

Every prepaid limited health service organization subject to this article shall pay to the commissioner the following fees:

(1) For filing an application for a certificate of authority or amendment thereto, two hundred dollars;

(2) For each renewal of a certificate of authority, the annual fee as provided in section thirteen, article three of this chapter;

(3) For each form filing and for each rate filing, the fee as provided in section thirty-four, article six of this chapter; and

(4) For filing each annual report, twenty-five dollars.

Fees charged under this section are for the purposes set forth in section thirteen, article three of this chapter.

§33-25D-25. Penalties and enforcement.

(a) The commissioner may, in lieu of suspension or revocation of a certificate of authority under section twenty 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 prepaid limited health service 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 or she calculates to be the damages suffered by enrollees or other members of the public.

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

(c)(1) If the commissioner, for any reason, has cause to believe that any violation of this article or rules 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 may give notice to the prepaid limited health service organization and to the representatives, or other persons who appear to be involved in the 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 the 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 the violation.

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

(d)(1) The commissioner may issue an order directing a prepaid limited health service organization or a representative of a prepaid limited health service organization to cease and desist from engaging in any act or practice in violation of the provisions of this article or rules promulgated pursuant this article.

(2) 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. The hearings shall be conducted pursuant to section thirteen, article two of this chapter.

(e) In the case of any violation of the provisions of this article or rules promulgated pursuant this article, 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 (d) of this section, the commissioner may institute a proceeding to obtain injunctive relief, or seek other appropriate relief, in the circuit court of the county of the principal place of business of the prepaid limited health service organization.

(f) Any enrollee of or resident of this state may bring an action against the prepaid limited health service organization to enforce any provision, standard or rule enforceable by the commissioner: *Provided,* That this subsection does not authorize a civil action against the commissioner, his or her employees or any other agency or instrumentality of this state. In the case of any successful action to enforce this article, or accompanying standards or rules, the individual shall be awarded the costs of the action together with a reasonable attorney's fee as determined by the court.

§33-25D-26. Statutory construction and relationship to other laws.

(a) Except as otherwise provided in this article, provisions of the insurance laws, provisions of hospital, medical, dental or health service corporation laws and provisions of health maintenance organization laws are not applicable to any prepaid limited health service organization granted a certificate of

authority under this article. The provisions of this article do not apply to an insurer, hospital, medical, dental or health service corporation, or health maintenance organization licensed and regulated pursuant to the insurance laws, hospital, medical, dental or health service corporation laws or health maintenance organization laws of this state except with respect to its prepaid limited health service corporation activities authorized and regulated pursuant to this article. The provisions of this article do not apply to an entity properly licensed by a reciprocal state to provide a limited health care service to employer groups, where residents of West Virginia are members of an employer group, and the employer group contract is entered into in the reciprocal state. For purposes of this subsection, a "reciprocal state" means a state which physically borders West Virginia and which has subscriber or enrollee hold harmless requirements substantially similar to those set out in section ten of 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 prepaid limited health service organization granted a certificate of authority, or its representative do not violate any provision of law relating to solicitation or advertising by health professions: *Provided,* That nothing contained in this subsection authorizes any solicitation or advertising which identifies or refers to any individual provider or makes any qualitative judgment concerning any provider.

(c) Any prepaid limited health service organization authorized under this article is not 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 nine, article two, examinations; section thirteen, article two, hearings; sections fifteen and twenty, article four, general provisions; section twenty, article five, borrowing by insurers; section seventeen, article six, noncomplying forms; article six-c, guaranteed loss ratio; article

seven, assets and liabilities; article eight, investments; article nine, administration of deposits; article ten, rehabilitation and liquidation; 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 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-d, marketing and rate practices for small employers; article twenty-seven, insurance holding company systems; article thirty-three, annual audited financial report; article thirty-four, administrative supervision; 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; article thirty-nine, disclosure of material transactions; and article forty-one, privileges and immunity, all of this chapter are applicable to any prepaid limited health service organization granted a certificate of authority under this article. In circumstances where the code provisions made applicable to prepaid limited health service organizations by this section refer to the "insurer," the "corporation" or words of similar import, the language includes prepaid limited health service organizations.

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

(f) A prepaid limited health service organization granted a certificate of authority under this article is exempt from paying municipal business and occupation taxes on gross income it receives from its enrollees, or from their employers or others on their behalf, for health care items or services provided directly or indirectly by the prepaid limited health service organization.

§33-25D-27. Filings and reports as public documents.

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

§33-25D-28. Confidentiality of medical information.

(a) 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 prepaid limited health service organization shall be held in confidence and may 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 eighteen of this article or to review the grievance procedure pursuant to section fourteen 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 prepaid limited health service organization where the data or information is pertinent;

(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 prepaid limited health service organization and the department or division of the state; or

(6) For a medicaid recipient enrolled under a group contract between a prepaid limited health service organization and the governmental agency responsible for administering the medicaid program, in accordance with confidentiality rules applicable to the medicaid program.

(b) A prepaid limited health service organization is entitled to claim any statutory privileges against the disclosure which

the provider who furnished the information to the prepaid limited health service organization is entitled to claim.

(c) Any information provided to the division of insurance that is part of the division investigation or examination is confidential and exempt from disclosure under subsection (a) of this section or otherwise until the investigation is completed or ceases to be active. For purposes of this subsection, an investigation is considered "active" while the investigation is being conducted by the division with a reasonable, good faith belief that it may lead to the filing of administrative, civil, or criminal proceedings. An investigation does not cease to be active if the division is proceeding with reasonable dispatch and there is a good faith belief that action may be initiated by the division or other administrative or law-enforcement agency. After an investigation or examination is completed or ceases to be active, portions of the records relating to the investigation or examination remain confidential and are exempt from disclosure under subsection (a) of this section or otherwise if the disclosure would:

(1) Jeopardize the integrity of another active investigation;

(2) Impair the safety and financial soundness of the licensee or affiliated party;

(3) Reveal personal financial information;

(4) Reveal the identity of a confidential source;

(5) Defame or cause unwarranted damage to the good name or reputation of an individual or jeopardize the safety of an individual; or

(6) Reveal investigative techniques or procedures.

§33-25D-29. Authority to contract with prepaid limited health service organizations under medicaid.

The department of health and human resources is authorized to enter into contracts with prepaid limited health service 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. § 1396,

et seq., limited health services offered to such recipients under the medical assistance plan of West Virginia. The children's health policy board, the department of health and human resources, and the division of juvenile services within the department of military affairs and public safety are further authorized to enter into contracts with prepaid limited health service organizations to furnish behavioral health services to adults and children who are eligible to receive such services under chapter five, chapter sixteen, chapter twenty-seven or chapter forty-nine of this code.

§33-25D-30. Authority of commissioner to propose rules regarding affiliate and subsidiary operating results.

The commissioner may after notice and hearing propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code to define the commissioner's authority to consider the operating results of an insurer's affiliates and subsidiaries in the rate making and solvency determination of that insurer.

That 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 from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker of the House of Delegates

The within approved this the 6th day of April, 1999.

Governor

PRESENTED TO THE
GOVERNOR
Date 3/26/99
Time 2:25 pm