

HB 2660

FILED

2009 MAY -4 PM 3: 18

OFFICE WEST VIRGINIA
SECRETARY OF STATE

WEST VIRGINIA LEGISLATURE
FIRST REGULAR SESSION, 2009



ENROLLED

**COMMITTEE SUBSTITUTE
FOR
House Bill No. 2660**

(By Delegates Perry, Shook, Moore and Reynolds)



Passed April 11, 2009

In Effect Ninety Days from Passage

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FOR OFFICE WEST VIRGINIA
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H. B. 2660

(BY DELEGATES PERRY, SHOOK, MOORE AND REYNOLDS)

[Passed April 11, 2009; in effect ninety days from passage.]

AN ACT to amend and reenact §33-25D-2 of the Code of West Virginia, 1931, as amended, relating to prepaid limited health service organizations; adding dental, vision, pharmaceutical and podiatric services to those services that may be offered by prepaid limited health service organizations.

Be it enacted by the Legislature of West Virginia:

That §33-25D-2 of the Code of West Virginia, 1931, as amended, be amended and reenacted to read as follows:

ARTICLE 25D. PREPAID LIMITED HEALTH SERVICE ORGANIZATION ACT.

§33-25D-2. Definitions.

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

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

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

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

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

30 (f) "Employee" means a person in some official
31 employment or position working for a salary or wage

32 continuously for no less than one calendar quarter and who
33 is in such a relation to another person that the latter may
34 control the work of the former and direct the manner in
35 which the work is done.

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

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

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

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

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

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

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

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

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

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

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

92 (n) "Limited health service" means mental or behavioral
93 health services (including mental illness, mental retardation,
94 developmental disabilities, substance abuse, and chemical
95 dependency services), dental care services, vision care
96 services, podiatric care services, pharmaceutical services
97 (including Medicare prescription drug plans), together with
98 any services or goods included in the furnishing to any
99 individual of a limited health service. "Limited health
100 service" does not include inpatient services, hospital surgical
101 services or emergency services except as such services are
102 provided incident to and directly related to a limited health
103 service set forth in this subsection.

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

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

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

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

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

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

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

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

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

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

146 (r) "Qualified independent actuary" means an actuary
147 who is a member of the American academy of actuaries or
148 the society of actuaries and has experience in establishing
149 rates for prepaid limited health service organizations and who
150 has no financial or employment interest in the prepaid limited
151 health service organization.

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

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

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

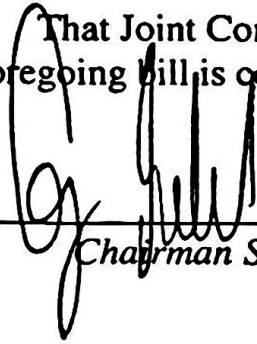
165 (v) "Surplus" means the amount by which a corporation's
166 assets exceed its liabilities and required reserves based upon
167 the financial information which would be required by this
168 chapter for the preparation of the corporation's annual
169 statement except that assets pledged to secure debts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

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

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

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

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



Chairman Senate Committee



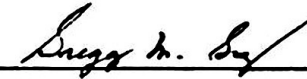
Chairman House Committee

Originating in the House.


In effect ninety days from passage.



Clerk of the Senate



Clerk of the House of Delegates



President of the Senate



Speaker of the House of Delegates

The within is approved this the 4th
day of May, 2009.



Governor

PRESENTED TO THE
GOVERNOR

APR 30 2009

Time 3:20pm