

SB 483

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WEST VIRGINIA LEGISLATURE

WEST VIRGINIA
SECRETARY OF STATE

SEVENTY-NINTH LEGISLATURE

REGULAR SESSION, 2010



ENROLLED

COMMITTEE SUBSTITUTE

FOR

Senate Bill No. 483

(SENATORS MINARD AND CHAFIN, *original sponsors*)

[Passed March 20, 2010; in effect ninety days from passage.]

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AN ACT to amend and reenact §33-25A-2 and §33-25A-5 of the Code of West Virginia, 1931, as amended, relating to health maintenance organizations; authority to provide a point of service option; and authority for the Office of the Insurance Commissioner to develop standards for a point of service option by legislative and emergency rule.

Be it enacted by the Legislature of West Virginia:

That §33-25A-2 and §33-25A-5 of the Code of West Virginia, 1931, as amended, be amended and reenacted to read as follows:

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-2. Definitions.

- 1 (1) "Basic health care services" means physician, hospi-
- 2 tal, out-of-area, podiatric, chiropractic, laboratory, X ray,
- 3 emergency, treatment for serious mental illness as pro-

4 vided in section three-a, article sixteen of this chapter, and
5 cost-effective preventive services including immuniza-
6 tions, well-child care, periodic health evaluations for
7 adults, voluntary family planning services, infertility
8 services, and children's eye and ear examinations con-
9 ducted to determine the need for vision and hearing
10 corrections, which services need not necessarily include all
11 procedures or services offered by a service provider.

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

16 (3) "Commissioner" means the commissioner of insur-
17 ance.

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

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

27 (6) "Employee" means a person in some official employ-
28 ment or position working for a salary or wage continu-
29 ously for no less than one calendar quarter and who is in
30 such a relation to another person that the latter may
31 control the work of the former and direct the manner in
32 which the work shall be done.

33 (7) "Employer" means any individual, corporation,
34 partnership, other private association, or state or local
35 government that employs the equivalent of at least two

36 full-time employees during any four consecutive calendar
37 quarters.

38 (8) "Enrollee", "subscriber" or "member" means an
39 individual who has been voluntarily enrolled in a health
40 maintenance organization, including individuals on whose
41 behalf a contractual arrangement has been entered into
42 with a health maintenance organization to receive health
43 care services.

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

47 (10) "Health care services" means any services or goods
48 included in the furnishing to any individual of medical,
49 mental or dental care, or hospitalization or incident to the
50 furnishing of the care or hospitalization, osteopathic
51 services, chiropractic services, podiatric services, home
52 health, health education or rehabilitation, as well as the
53 furnishing to any person of any and all other services or
54 goods for the purpose of preventing, alleviating, curing or
55 healing human illness or injury.

56 (11) "Health maintenance organization" or "HMO"
57 means a public or private organization which provides, or
58 otherwise makes available to enrollees, health care
59 services, including at a minimum basic health care services
60 and which:

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

64 (B) Provides physicians' services primarily: (i) Directly
65 through physicians who are either employees or partners
66 of the organization; or (ii) through arrangements with
67 individual physicians or one or more groups of physicians
68 organized on a group practice or individual practice

69 arrangement; or (iii) through some combination of para-
70 graphs (i) and (ii) of this subdivision;

71 (C) Assures the availability, accessibility and quality,
72 including effective utilization, of the health care services
73 which it provides or makes available through clearly
74 identifiable focal points of legal and administrative
75 responsibility; and

76 (D) Offers services through an organized delivery system
77 in which a primary care physician or primary care pro-
78 vider is designated for each subscriber upon enrollment.
79 The primary care physician or primary care provider is
80 responsible for coordinating the health care of the sub-
81 scriber and is responsible for referring the subscriber to
82 other providers when necessary: *Provided*, That when
83 dental care is provided by the health maintenance organi-
84 zation the dentist selected by the subscriber from the list
85 provided by the health maintenance organization shall
86 coordinate the covered dental care of the subscriber, as
87 approved by the primary care physician or the health
88 maintenance organization.

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

99 (13) "Individual practice arrangement" means any
100 agreement or arrangement to provide medical services on
101 behalf of a health maintenance organization among or
102 between physicians or between a health maintenance
103 organization and individual physicians or groups of

104 physicians, where the physicians are not employees or
105 partners of the health maintenance organization and are
106 not members of or affiliated with a medical group.

107 (14) “Insolvent” or “insolvency” means a financial
108 situation in which, based upon the financial information
109 that would be required by this chapter for the preparation
110 of the health maintenance organization’s annual state-
111 ment, the assets of the health maintenance organization
112 are less than the sum of all of its liabilities and required
113 reserves.

114 (15) “Medical group” or “group practice” means a
115 professional corporation, partnership, association or other
116 organization composed solely of health professionals
117 licensed to practice medicine or osteopathy and of other
118 licensed health professionals, including podiatrists,
119 dentists and optometrists, as are necessary for the provi-
120 sion of health services for which the group is responsible:
121 (a) A majority of the members of which are licensed to
122 practice medicine or osteopathy; (b) who as their principal
123 professional activity engage in the coordinated practice of
124 their profession; (c) who pool their income for practice as
125 members of the group and distribute it among themselves
126 according to a prearranged salary, drawing account or
127 other plan; and (d) who share medical and other records
128 and substantial portions of major equipment and profes-
129 sional, technical and administrative staff.

130 (16) “Point of service option” means a delivery system
131 that permits an enrollee to receive health care services
132 from a provider outside of the panel of providers with
133 which the health maintenance organization has a contrac-
134 tual arrangement under the terms and conditions of the
135 enrollee’s contract with the health maintenance organiza-
136 tion or the insurance carrier that provides the point of
137 service option.

138 (17) "Premium" means a prepaid per capita or prepaid
139 aggregate fixed sum unrelated to the actual or potential
140 utilization of services of any particular person which is
141 charged by the health maintenance organization for health
142 services provided to an enrollee.

143 (18) "Primary care physician" means the general practi-
144 tioner, family practitioner, obstetrician/gynecologist,
145 pediatrician or specialist in general internal medicine who
146 is chosen or designated for each subscriber who will be
147 responsible for coordinating the health care of the sub-
148 scriber, including necessary referrals to other providers.

149 (19) "Primary care provider" means a person who may
150 be chosen or designated in lieu of a primary care physician
151 for each subscriber, who will be responsible for coordinat-
152 ing the health care of the subscriber, including necessary
153 referrals to other providers, and includes:

154 (A) An advanced nurse practitioner practicing in compli-
155 ance with article seven, chapter thirty of this code and
156 other applicable state and federal laws, who develops a
157 mutually agreed upon association in writing with a
158 primary care physician on the panel of and credentialed by
159 the health maintenance organization; and

160 (B) A certified nurse-midwife, but only if chosen or
161 designated in lieu of a subscriber's primary care physician
162 or primary care provider during the subscriber's preg-
163 nancy and for a period extending through the end of the
164 month in which the sixty-day period following termina-
165 tion of pregnancy ends.

166 (C) Nothing in this subsection may be construed to
167 expand the scope of practice for advanced nurse practitio-
168 ners as governed by article seven, chapter thirty of this
169 code or any legislative rule, or for certified nurse-mid-
170 wives, as defined in article fifteen, chapter thirty of this
171 code.

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

175 (21) "Uncovered expenses" means the cost of health care
176 services that are covered by a health maintenance organi-
177 zation, for which a subscriber would also be liable in the
178 event of the insolvency of the organization.

179 (22) "Service area" means the county or counties ap-
180 proved by the commissioner within which the health
181 maintenance organization may provide or arrange for
182 health care services to be available to its subscribers.

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

186 (24) "Surplus" means the amount by which a corpora-
187 tion's assets exceeds its liabilities and required reserves
188 based upon the financial information which would be
189 required by this chapter for the preparation of the corpora-
190 tion's annual statement except that assets pledged to
191 secure debts not reflected on the books of the health
192 maintenance organization shall not be included in surplus.

193 (25) "Surplus notes" means debt which has been subor-
194 dinated to all claims of subscribers and general creditors
195 of the organization.

196 (26) "Qualified independent actuary" means an actuary
197 who is a member of the American academy of actuaries or
198 the society of actuaries and has experience in establishing
199 rates for health maintenance organizations and who has
200 no financial or employment interest in the health mainte-
201 nance organization.

202 (27) "Quality assurance" means an ongoing program
203 designed to objectively and systematically monitor and
204 evaluate the quality and appropriateness of the enrollee's

205 care, pursue opportunities to improve the enrollee's care
206 and to resolve identified problems at the prevailing
207 professional standard of care.

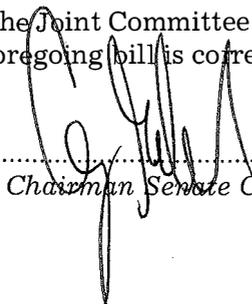
208 (28) "Utilization management" means a system for the
209 evaluation of the necessity, appropriateness and efficiency
210 of the use of health care services, procedure and facilities.

§33-25A-5. Powers of health maintenance organizations.

1 (a) Upon obtaining a certificate of authority as required
2 under this article, a health maintenance organization may
3 enter into health maintenance contracts in this state and
4 engage in any activities, consistent with the purposes and
5 provisions of this article, which are necessary to the
6 performance of its obligations under such contracts,
7 subject to the limitations provided in this article. A health
8 maintenance organization may offer to its enrollees in
9 conjunction with the benefits provided to them through
10 their contractual arrangement for health services with the
11 health maintenance organization a point of service option
12 to be provided either by the health maintenance organiza-
13 tion directly or by an insurance carrier licensed in this
14 state with which the health maintenance organization has
15 a contractual arrangement. Benefits for health care
16 services within the health maintenance organization's
17 contracted provider panel shall comply with all other
18 provisions of this article.

19 (b) The commissioner shall propose rules for legislative
20 approval in accordance with the provisions of article
21 three, chapter twenty-nine-a of this code limiting or
22 regulating the powers of health maintenance organizations
23 which the commissioner finds to be in the public interest.
24 The commissioner may promulgate emergency rules
25 pursuant to the provisions of section fifteen, article three,
26 chapter twenty-nine-a of this code to implement standards
27 and requirements for a point of service option.

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



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Chairman Senate Committee



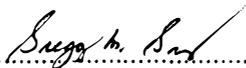
.....
Chairman House Committee

Originated in the Senate.

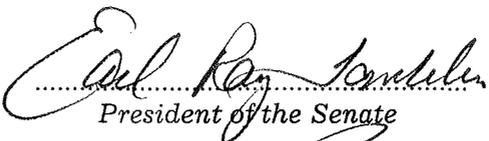
In effect ninety days from passage.



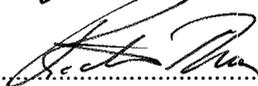
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Clerk of the Senate



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Clerk of the House of Delegates



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President of the Senate



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Speaker House of Delegates

The within is approved this the 7th

Day of April, 2010.



.....
Governor

PRESENTED TO THE
GOVERNOR

APR 01 2010

Time 4:15 pm