

**TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER**

**SERIES 91
HEALTH MAINTENANCE ORGANIZATION POINT OF SERVICE OPTION**

Section.

- 114-91-1. General
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HEALTH MAINTENANCE ORGANIZATION POINT OF SERVICE OPTION**

§114-91-1. General.

1.1. Scope. -- The purpose of this rule is to set forth requirements to be followed by health maintenance organizations that offer a point of service option to its enrollees.

1.2. Authority. -- W.Va. Code §§33-25A-5(b) and 33-2-10.

1.3. Filing Date. --

1.4. Effective Date. --

§114-91-2. Definitions.

2.1. “Commissioner” means the Insurance Commissioner of the State of West Virginia.

2.2. “Enrollee” means an individual who has been voluntarily enrolled in a health maintenance organization, including individuals on whose behalf a contractual arrangement has been entered into with a health maintenance organization to receive health care.

2.3. “Health care services” means any services or goods included in the furnishing to any individual of medical, mental or dental care, or hospitalization or incident to the furnishing of the care or hospitalization, osteopathic services, chiropractic services, podiatric services, home health, health education or rehabilitation, as well as the furnishing to any person of any and all other services or goods for the purpose of preventing, alleviating, curing or healing human illness or injury.

2.4. “In-plan covered services” means health care services provided by a provider that is within the panel of providers with which a health maintenance organization has a contractual agreement.

2.5. “Out-of-plan covered services” means health care services provided by a provider that is not within the panel of providers with which a health maintenance organization has a contractual agreement.

2.6. “Point of service option” means a delivery system that permits an enrollee to receive health care services from a provider outside of the panel of providers with which a health maintenance organization has a contractual agreement under the terms and conditions of the enrollee’s contract with the health maintenance organization or an insurance carrier that provides the point of service option.

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2.7. “Provider” means a person or other entity which holds a valid license to provide health care services.

§114-91-3. Requirements for Point of Service Option.

3.1. A health maintenance organization that offers a point of service option pursuant to W. Va. Code §33-25A-5(a):

3.1.a. Must include as in-plan covered services all services required by law to be provided by a health maintenance organization;

3.1.b. Must provide incentives, which shall include financial incentives, for enrollees to use in-plan covered services;

3.1.c. May not offer services out of plan without providing those services on an in-plan basis;

3.1.d. May not consider emergency services, authorized referral services, or non-routine services obtained out of the service area to be point of service services;

3.1.e. May treat as out-of-plan covered services those services that an enrollee obtains from a participating provider, but for which the proper authorization was not given by the health maintenance organization; and

3.1.f. Must include the following disclosure on its point of service contracts and evidences of coverage:

“WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating providers are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy’s fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill.

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Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.”

3.2. A health maintenance organization offering a point of service option is subject to all of the following limitations:

3.2.a. The health maintenance organization may not expend in any calendar quarter more than twenty percent (20%) of its total expenditures for all its members for out-of-plan covered services.

3.2.b. If the amount specified in subdivision a of this subsection is exceeded by two percent (2%) in a quarter, the health maintenance organization must effect compliance with subdivision a of this subsection by the end of the following quarter.

3.2.c. If compliance with the amount specified in subdivision a of this subsection is not demonstrated in the health maintenance organization’s next quarterly report, the health maintenance organization may not offer the point of service option to new groups or include the point of service option in the renewal of an existing group until compliance with the amount specified in subdivision a of this subsection is demonstrated or until otherwise allowed by the Commissioner.

3.2.d. A health maintenance organization failing, without just cause, to comply with the provisions of this subsection shall be required, after notice and hearing, to pay a penalty of \$250 for each day out of compliance, to be recovered by the Commissioner. The Commissioner may reduce the penalty if the health maintenance organization demonstrates to the Commissioner that the imposition of the penalty would constitute a financial hardship to the health maintenance organization.

3.3. A health maintenance organization that offers a point of service option must do all of the following:

3.3.a. File a quarterly financial statement detailing compliance with the requirements of subsection 3.2 of this rule.

3.3.b. Track out-of-plan, point of service utilization separately from in-plan or non-point of service, out-of-plan emergency care, referral care, and urgent care out of the service area utilization.

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3.3.c. Record out-of-plan utilization in a manner that will permit such utilization and cost reporting as the Commissioner may require.

3.3.d. Demonstrate to the Commissioner's satisfaction that the health maintenance organization has the fiscal, administrative, and marketing capacity to control its point of service enrollment, utilization, and costs so as not to jeopardize the financial security of the health maintenance organization.

3.3.e. Maintain, in addition to the deposit required by W. Va. Code §33-25A-4(h), a deposit in an amount that is not less than the greater of one hundred twenty-five percent (125%) of the health maintenance organization's annual projected point of service claims or \$200,000.

3.3.f. Maintain cash and cash equivalents of sufficient amount to fully liquidate ten days' average claim payments, subject to review by the Commissioner.

3.3.g. Maintain and file with the Commissioner, reinsurance coverage protecting against catastrophic losses on out of network point of service services. Deductibles may not exceed \$100,000 per covered life per year, and the portion of risk retained by the health maintenance organization once deductibles have been satisfied may not exceed twenty percent (20%). Reinsurance must be placed with licensed authorized reinsurers qualified to do business in West Virginia.

3.4. A health maintenance organization may not issue a point of service contract until it has filed and had approved by the Commissioner a plan to comply with the provisions of this section. The compliance plan must, at a minimum, include provisions demonstrating that the health maintenance organization will do all of the following:

3.4.a. Design the benefit levels and conditions of coverage for in-plan covered services and out-of-plan covered services as required by this rule.

3.4.b. Provide or arrange for the provision of adequate systems to:

3.4.b.1. Process and pay claims for all out-of-plan covered services;

3.4.b.2. Meet the requirements for point of service options set forth in this rule and any additional requirements that may be set forth by the Commissioner; and

3.4.b.3. Generate accurate data and financial and regulatory reports on a timely basis so that the Commissioner can evaluate the health maintenance organization's experience with the point of service option and monitor compliance with point of service option provisions.

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3.4.c. Comply with the requirements of subsections 3.2 and 3.3 of this rule.