

July, 1996

WEST VIRGINIA INFORMATIONAL LETTER

NO. 98

TO: ALL HEALTH MAINTENANE ORGANIZATIONS LICENSED IN WEST VIRGINIA AND ALL PENDING HMO LICENSE APPLICANTS

RE: SIGNIFICANT 1996 HMO STATUTORY CHANGES

The purpose of this Informational Letter is to briefly summarize and to place interested parties on notice of significant 1996 changes in HMO regulatory requirements. This letter should not be construed as a comprehensive list or comprehensive explanation of such changes. Interested parties should consult the relevant statutes, legislative rules, and case law for complete HMO regulatory requirements. Reference should also be made to Informational Letter 96 for other significant 1996 law changes.

STATUTORY CHANGES -- H.B. 4511

House Bill 4511 becomes effective on June 7, 1996 and adds several regulatory requirements for HMOs. These include:

STAFFING

- Chiropractic care must be included as a basic health care service.
- Nurse Midwives are now permitted to serve in lieu of a primary care physician during the period of pregnancy and sixty (60) days after the pregnancy.

QUALITY ASSURANCE

- "Quality Assurance" and "Utilization Review" are now specifically defined by statute.

- A description of an HMOs Quality Assurance Program must now accompany its application for a Certificate of Authority. This includes renewal applications for Certificates of Authority. If an HMO is filing its initial application for a Certificate of Authority, the Insurance Commissioner must make a determination as to the feasibility of the proposed Quality Assurance Program of the applicant.

- By May 1, 1998, all HMOs, which have been in business for at least three years, must have obtained a Quality Assurance Program review by a nationally recognized accreditation and review organization which has been approved by the Insurance Commissioner. Upon receipt of the report of the National Accreditation and Review Organization, the HMO must provide a copy to the Insurance Commissioner within thirty (30) days.
Accreditation by the National Accreditation and Review Organization is not required by the statute. The Insurance Commissioner will use the report of the National Accreditation and Review Organization to determine areas of deficiency in the HMOs Quality Assurance Program and may dictate a corrective action plan.

- The Insurance Commissioner must promulgate utilization review standards by legislative rule.

ANNUAL EXPIRATION OF HMO CERTIFICATES OF AUTHORITY

- Beginning in 1997, all HMO Certificates of Authority will expire at midnight on May 31st of each year. An HMO must reapply for its Certificate of Authority on a form which will be developed by the Insurance Commissioner and pay the appropriate renewal fee.
- Certificates of Authority will not be renewed if after twelve months an HMO has no subscribers.
- HMOs applying for renewal of existing Certificates of Authority must meet all criteria required for initial licensure.

REINSURANCE

- If HMOs obtain reinsurance, it must be with an accredited reinsurer.

BLANKET FIDELITY BOND

- HMOs are required to maintain a blanket fidelity bond on all personnel who handle funds.

MANDATORY STATEMENT IN EVIDENCE OF COVERAGE

- The following exact statement must appear in bold print in the subscribers evidence of coverage. "Each Subscriber or Enrollee, by acceptance of the benefits described in this evidence of coverage, shall be deemed to have consented to the examination of his or her medical records for purposes of Utilization Review, Quality Assurance and Peer Review by the Health Maintenance Organization or its designee."

RATES

In reviewing an HMOs rate filing, the Insurance Commissioner must, in addition to other criteria, now also consider whether the HMO has made a good faith effort to support community health efforts.

MEDICAID

- Information to enrollees. The annual HMO performance summary, which must be provided to subscribers at present, may be provided to Medicaid subscribers by making a copy available at the area Medicaid program-office.
- Enrollee composition. The former, state imposed, seventy-five percent (75%) Medicaid and Medicare enrollment ceiling has been eliminated. Federal requirements with respect to enrollee composition are not affected by this legislation.

ADVERTISING

- Prior approval by the Insurance Commissioner of all HMO advertising is required.

MARKETING

- With respect to groups of twenty-five (25) subscribers or more, subscriber intent to enroll verification requirements have been removed. Verification requirements as to all other groups and individuals remain unchanged.
- The subscriber confirmation form has been slightly revised. Current subscriber verification and confirmation forms are attached to this informational letter as Exhibit A and Exhibit B, respectively.

LICENSURE AND RECIPROCAL STATES

- There is an exemption created from HMO licensure requirements where a proper employer group has been written by a properly licensed entity in an adjoining state and that group contains West Virginia members. This exemption applies only if the adjoining state has subscriber hold harmless requirements similar to those of West Virginia.

AMBULANCE/EMERGENCY MEDICAL SERVICES

- The Insurance Commissioner is required to promulgate rules as expeditiously as possible to regulate HMOs in contracting for ambulance and other emergency medical services.

TAXATION

- HMOs are exempted from the West Virginia Municipal Business and Occupation Tax for tax years through and including 1996. The Insurance Commissioner and Tax Department are required to study the issue of taxation of HMOs and to report to the Legislature in the 1997 Regular Session.

RURAL HMOs

- The Insurance Commissioner is required to prepare a proposal on the concept of rural HMOs for presentation to the State Legislature during the 1997 Regular Session. This proposal is to incorporate standards less restrictive than those required of traditional HMOs.

STATUTORY CHANGES -- H.B. 4207

- House Bill 4207 creates an HMO Guaranty Association and all HMOs operating in West Virginia are required to participate.

- Licensure or relicensure as an HMO is conditioned upon payment by the HMO of all Guaranty Association Assessments.

LEGISLATIVE RULE CHANGES, 114-43-1 et. seq.

INTERMEDIARY CONTRACTS

- Series 43 of the Insurance Commissioners Legislative Rules became effective on April 3, 1996. These rules regulate intermediate (and not licensed by the Insurance Commissioner) entities which are assuming any risk for the provision of health care to members or subscribers.
- Direct contracting between risk bearing intermediaries and subscribers is prohibited. Such entities must operate through an arrangement with an entity licensed by the Insurance Commissioner such as an HMO.
- HMO contracts with intermediaries must be filed with the Insurance Commissioner and meet certain solvency and consumer protection criteria.
- This rule does not affect the normal non-risk contract directly between an HMO and a health care provider operating only under its own medical or professional license.

Questions concerning this Information Letter should be directed to John Davidson, Director of Consumer Service, State of West Virginia Offices of the Insurance Commissioner, Post Office Box 50540, Charleston, West Virginia 25305-0540.

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Insurance Commissioner