TITLE 114

LEGISLATIVE RULE

INSURANCE COMMISSIONER

SERIES 43

HEALTH MAINTENANCE ORGANIZATIONS

§114-43-1. General.

1.1. Scope. -- This rule applies to all persons or entities which are licensed or which may be required to be licensed pursuant to the provisions of W. Va. Code §33-25A-1 et seq.

1.2. Authority. -- W. Va. Code

§§33-25A-3(3) 5, 20.

1.3. Filing Date. -- April 3, 1996.

1.4. Effective Date. -- April 3, 1996.

§114-43-2. Definitions.

2.1. "Administrative health service contract" means an agreement between a certificate of authority holder and a health service intermediary or between health service intermediaries in which:

a. The intermediary accepts payments, including payments on a fixed per capita fixed aggregate sum or percentage of premium basis, from the certificate of authority holder or from another health service intermediary for one or more health care services to be rendered by providers to subscribers, members, policyholders, or certificateholders, as applicable, of a certificate of authority holder, where the intermediary assumes financial risk for payments to providers; and

b. The intermediary contracts with providers to render one or more health care services to subscribers, policyholders or certificateholders, as applicable, of a certificate of authority holder.

2.2. "Certificate of authority holder" means an entity which holds a valid certificate of authority from the commissioner to operate a health maintenance organization under W. Va. Code §33-25A-1 et seq.

2.3. "Commissioner" means the Insurance Commissioner of the State of West Virginia.

2.4. "Financially sound" or "fiscally and financially sound" means that according to presently accepted actuarial standards of practice, consistently applied and fairly stated, that the respective considerations to the parties under the contract, including, but not limited to, reserves, the investment earnings on such considerations, the considerations anticipated to be received and retained by the parties under the contract, and related actuarial values, make adequate provision for the anticipated cash flows required by the contractual obligations and related expenses of the parties.

2.5. "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 and optometrists, as are necessary for the provision of the health services for which the group is responsible: a. who engage in a single field of medical practice or specialty or who all practice at a single location; b. a majority of the members of which are licensed to practice medicine or osteopathy; c. who as their principal professional activity engage in the coordinated practice of their profession; d. 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 e. who share medical and other records and substantial portions of major equipment and professional, technical and administrative staff.

2.6. "Health care services" or "health services" means services, medical equipment, and supplies furnished by a provider, which may include, but which are not limited to, medical, surgical, or dental care; psychological, optometric, optic, chiropractic, podiatric, nursing, physical therapy, mental health, substance abuse, or pharmaceutical services; health education, preventive medical, rehabilitative, or home health services; inpatient or outpatient hospital services; extended care; nursing home care; convalescent institutional care; technical and professional clinical pathology laboratory services; laboratory and ambulance services; appliances, drugs, medicines, and supplies; or any other care, service, or treatment of disease, or correction of defects for human beings.

2.7. "Health service intermediary" or "intermediary" means a physician, hospital, physician-hospital organization, independent provider organization, independent provider network, or other entity or person that arranges for one or more health care services to be rendered by providers to subscribers, policyholders, or certificateholders, as applicable, of a certificate of authority holder. "Health service intermediary" or "intermediary" does not include:

a. A provider directly contracting with a certificate of authority holder for the provider to render health care services, when that provider renders those services directly and only through its own professional license or licenses or, in the case when the provider is a "group practice" the group practice utilizes only its employees, partners or shareholders and their professional licenses to render those services.

b. A certificate of authority holder.

2.8. "Incurred but not reported health care costs" or "IBNR" means the cost of health care services rendered to subscribers, policyholders or certificateholders, as applicable, of a certificate of authority holder by providers during the reporting period and for which the health service intermediary is financially responsible, but which are not reported to the intermediary until after the reporting period.

2.9. "Independent certified public accountant" means an independent certified public accountant who holds a valid license to practice, issued by the state in which he or she resides or has his or her principal place of business who has experience auditing or performing accounting functions for health maintenance organizations and who does not have a financial or other interest in a given entity which could influence his or her professional judgement.

2.10. "Provider" means a person or other entity which holds a valid license to provide specific health care services in the State of West Virginia.

2.11. "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 health maintenance organizations and who has no financial or employment interest in the certificate of authority holder or the health care intermediary.

§114-43-3. Intermediary Contract Requirements.

3.1. A certificate of authority holder may not enter into an administrative health service contract with a health service intermediary unless the contract is in writing, is filed with the commissioner accompanied by an opinion by a qualified independent actuary which states that the entering of the contract by the certificate of authority holder is financially sound, and the contract contains provisions which:

a. Require the health service intermediary to provide the certificate of authority holder with regular written reports prepared on a West Virginia statutory accounting basis, at least quarterly, that state the health service intermediary's current assets and identify in the aggregate all payments made or owed to its providers in sufficient detail for the certificate of authority holder and the Commissioner to determine if the payments are being made in a timely manner and which identify in the aggregate the reasonably estimated incurred but not reported health care costs;

b. Require the certificate of authority holder to monitor the health service intermediary's reports required under paragraph a of this subsection;

c. Permit the certificate of authority holder and the commissioner, both singularly and jointly, upon reasonable prior notice, to audit, inspect and copy the health service intermediary's books, records, and other evidence of its operations which are, in the discretion of the certificate of authority holder or the commissioner, relevant to the intermediary's obligations under the administrative health service contract for the purpose of determining the intermediary's compliance with all requirements legally mandated by statute, rule or the administrative health service contract. Any review is subject to any confidentiality requirements imposed by State or Federal law;

d. Require the health service intermediary to maintain working capital in the form of cash or equivalent liquid assets at least equal to one month's claims calculated by using the monthly average of actual and estimated claims for the prior six months for all health services provided under the administrative health service contract;

e. Require the intermediary to create a segregated fund, which may be aggregated, equal to the entire monthly IBNR as of the first day of each month as actuarially determined by the certificate of authority holder.

A. The commissioner may upon application of the certificate of authority holder and good cause shown, give prior written approval to alternative financial arrangements between the certificate of

authority holder and the intermediary, such as the use of premium withhold funds, either in conjunction with or in lieu of the capital and reserve fund requirements of paragraphs d and e of this section;

f. Require the certificate of authority holder to assume the full financial responsibility as specified in subsection 4.2. of this rule, for any valid claims presented for payment to the health service intermediary by providers for covered health care services rendered to a subscriber, policyholder, enrollee or certificate holder, as applicable, and which are not paid by the health service intermediary as provided by law and by the contract between the intermediary and provider;

g. Require that all enrollee or enrollee group contracts must be directly with the certificate of authority holder and not the intermediary;

h. Require that the intermediary provide services on behalf of the certificate of authority holder only in counties where the certificate of authority holder is authorized by the commissioner to operate;

i. Clearly delineate the responsibilities to be assumed by the intermediary and require that the intermediary adhere to all quality and accessibility standards to which the certificate of authority holder is subject;

j. Require that to the extent the intermediary is permitted to sub-contract the provision of health care services that all sub-contractors must adhere to quality and accessibility standards to which the certificate of authority holder is subject;

k. Require that the certificate of authority holder continuously monitor the intermediaries' compliance with the contract requirements;

l. Specify that the certificate of authority holder is responsible for maintaining appropriate levels of capital, surplus, claims reserves, and other financial criteria as established pursuant to statute or rule;

m. Require the health service intermediary and any entities with which the health service intermediary sub-contracts for the provision of health care services to obtain and provide to the certificate of authority holder no later than the first day of June of each year an annual audited financial report prepared by an independent certified public accountant; and

n. If the health service intermediary provides health care services on behalf of more than one entity, specify that the health service intermediary maintain records which are adequate to clearly differentiate the transactions which relate to the provision of health care services on behalf of the certificate of authority holder.

§114-43-4. HMO Requirements.

4.1. Upon entry of a health service intermediary contract, a certificate of authority holder shall immediately file with the commissioner a full executed copy of the contract and all exhibits, attachments, addenda, schedules or other documents relevant to the contract.

a. Upon filing a health service intermediary contract with the commissioner, the certificate of authority holder shall simultaneously file the opinion of a qualified independent actuary which expresses the opinion of the qualified independent actuary that the entry of the contract by the certificate of authority holder:

A. Is a fiscally and financially sound transaction;

B. Does not cause excessive payments to the intermediary;

C. Provides for reasonable incentives to the intermediary for cost control; and

D. Does not contribute to the escalation of the cost of providing health care to enrollees.

4.2. A certificate of authority holder is financially responsible for any valid claims for covered health care services, exclusive of unpaid claims of providers who have contracted with the health service intermediary, presented for payment to a health service intermediary and which are not paid by the health service intermediary.

4.3. All affected master group contracts or evidences of coverage must reflect that the certificate of authority holder retains financial responsibility as specified in subsection 4.2. of this rule when health care services are provided through a health care intermediary.

4.4. A certificate of authority holder is responsible for compliance by the health care intermediary with all applicable standards required by W. Va. Code §33-25A-1, et. seq. as to any services performed on behalf of the certificate of authority holder.

4.5. No health care intermediary may contract directly with enrollees or subscribers without first having obtained a certificate of authority to operate a health maintenance organization.

4.6. All financial statements provided by the certificate of authority holder to the commissioner must fully and accurately reflect on a West Virginia statutory accounting basis the costs and liabilities to the certificate of authority holder associated with any health service intermediary contract including those liabilities assumed by the health service intermediary.

4.7. A certificate of authority holder is responsible for taking all reasonable measures to provide the commissioner full access to all books and records of any health service intermediary with which it contracts and to the books and records of any entity with which the intermediary sub-contracts for the provision of health care services, to the same extent the commissioner is given access to the books and records of the certificate of authority holder pursuant to W. Va. Code §§33-25A-17 and 33-2-9. The certificate of authority holder is financially responsible for any costs of examining the books and records of the health service intermediary or sub-contractor consistent with W. Va. Code §33-2-9.

4.8. A certificate of authority holder must within ten days of receipt of the annual audited financial report of a health service intermediary, file a full copy of the report with the commissioner.

4.9. The commissioner may require immediate cancellation or renegotiation of any administrative health service contract when the commissioner determines that the contract does any of the following:

a. Provides for excessive payments;

b. Fails to include reasonable incentives for cost control; or

c. Otherwise substantially or unreasonably contributes to the escalation of the cost of providing health care services to enrollees.

§114-43-5. Guarantees.

5.1. A health service intermediary's obligations, pursuant to paragraphs 3.1.d and 3.1.e. may be fulfilled by the unconditional, irrevocable guarantee of a parent, sister or affiliated entity which:

a. Has been in operation for five years or more and has a surplus on a West Virginia statutory accounting basis, not including land, buildings, and equipment, of greater than $2 million. In any determination of the financial condition of the guaranteeing operation, investments in or loans to any organizations guaranteed by the guaranteeing organization shall be excluded from surplus. If the guaranteeing organization is sponsoring more than one organization, the surplus requirement shall be increased by a multiple equal to the number of organizations;

b. Submits a guarantee that is approved by the commissioner in writing as meeting the requirements of this section. The written guarantee must contain a provision which requires that the guarantee be irrevocable unless the guaranteeing organization can demonstrate to the commissioner that the cancellation of the guarantee will not result in the insolvency of the intermediary and the commissioner approves in writing the cancellation of the guarantee;

c. Initially submits its audited financial statements, certified by an independent certified public accountant, prepared in accordance with generally accepted accounting principles, covering its two most current annual accounting periods; and

d. Submits annually, within three (3) months after the end of its fiscal year, an audited financial statement certified by an independent certified public accountant, prepared in accordance with generally accepted accounting principles. The commissioner may, as he or she considers necessary, require quarterly financial statements from the guaranteeing organization.

§114-43-6. Separability.

6.1. If any provision of this rule is held invalid, the remainder of this rule shall not be affected thereby.