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SECRETARY OF STATE
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ADMINISTRATIVE LAW DIVISION

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NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY W. Va. Code § 33-25A-3(3), 5, and 20

AMENDMENT TO AN EXISTING RULE: YES____ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: Series 43

TITLE OF RULE BEING PROPOSED: Health Maintenance Organization

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

B. Keith Huffman
General Counsel
Authorized Signature

14-30

STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Legal Division

GASTON CAPERTON
Governor

HANLEY C. CLARK
Insurance Commissioner

CONSENT TO FILING OF RULE

To Whom It May Concern:

Pursuant to West Virginia Code § 5F-2-2(a)(12), the undersigned hereby grants consent to the filing of the following rule proposed by the Insurance Commissioner of the State of West Virginia: Title 114, Series 43, relating to "Health Maintenance Organizations".

Signed this 26th day of June, 1995.

James H. Paige, III
Secretary of Tax and Revenue

2019 Washington Street, East
P.O. Box 50540
Charleston, West Virginia 25305-0540

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Insurance Commissioner
Legislative Rule
Title 114, Series 43

HEALTH MAINTENANCE ORGANIZATIONS

Title 114, Series 43

STATEMENT OF CIRCUMSTANCES

On March 11, 1995, the West Virginia Legislature passed House Bill 2619 which substantially rewrote Chapter 33, Article 25A of the West Virginia Code relating to Health Maintenance Organizations (HMO). The bill became effective 90 days from passage. The bill at § 33-25A-3(3) mandates that the Insurance Commissioner "promulgate rules to facilitate the enforcement of this subsection ..."

The rule sets forth requirements for entities which do not hold an HMO license, but which contract with an HMO to do a portion of the functions which the licensed HMO would ordinarily perform. The rules are intended to protect the public by securing financial solvency of these entities and by requiring them to live up to the same quality and accessibility of health care standards to which the HMO is subject.

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Title 114, Series 43
Health Maintenance Organizations

Type of Rule: _X_ Legislative ____ Interpretive ____ Procedural

Agency: INSURANCE COMMISSIONER

Address: Post Office Box 50540
2019 Washington Street, East
Charleston, West Virginia 25305-0540

==========

1. **Effect of Proposed Rule**

	ANNUAL		FISCAL YEAR		
	Increase	Decrease	Current	Next	Thereafter
ESTIMATED TOTAL COST	None				
PERSONAL SERVICES	None				
CURRENT EXPENSE	None				
REPAIRS AND ALTERNATIONS	None				
EQUIPMENT	None				
OTHER	None				

2. **Explanation of above estimates:**

The rule will be no discernable fiscal impact.

3. **Objectives of these rules:**

To regulate the use of health care intermediary contracts by Health Maintenance Organizations and thereby assure financial solvency of entities providing health care delivery through managed care arrangements.

Rule Title: Health Maintenance Organization

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

No measurable impact.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

There should be no measurable financial impact. The rule simply sets criteria for contracts between Health Maintenance Organizations and HMO health care providers who are assuming the financial risk of the (HMO).

C. Economic Impact on Citizens/Public at Large.

There will be no measurable impact, however, the rule is designed to protect the public from the insolvency of an HMO by preventing the insolvency.

Date: June 26, 1995

Signature of Agency Head or Authorized Representative

R. Keith Huffman, General Counsel

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER

DATE: July 31, 1995

LEGISLATIVE RULE TITLE: Health Maintenance Organizations
(Title 114, Series 43)

1. Authorizing statute(s) citation W. Va. Code § 33-25A-3(3), 5 & 20

2. a. Date filed in State Register with Notice of Hearing:

June 28, 1995

b. What other notice, including advertising, did you give of the hearing?

None

c. Date of hearing(s): Comment period ended on

July 28, 1995

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached XX No comments received ____

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)

July 31, 1995

f. Name and phone number of agency person to contact for additional information:

B. Keith Huffman

General Counsel

(304) 558-0401

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

   a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

      Not applicable

   b. Date of hearing: Not applicable

   c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

      Not applicable

   d. Attach findings and determinations and reasons:

      Attached Not applicable

Insurance Commissioner
Legislative Rule
Title 114, Series 43

HEALTH MAINTENANCE ORGANIZATIONS

Title 114, Series 43

BRIEF SUMMARY OF RULE

This rule dictates conditions which must be complied with if a Health Maintenance Organization (HMO) enters into a risk shifting contract with a health care intermediary for the intermediary to provide health care to the HMO's members. The rule does not apply to doctors & hospitals which enter into ordinary fee for service contracts. The rule establishes reporting and financial solvency requirements that must be met by intermediaries who take on a portion of the risks and responsibilities for health care services that would otherwise be those of the licensed HMO. Licenses for such intermediaries are not generally required.

114CSR43

WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 43
HEALTH MAINTENANCE ORGANIZATIONS

Section

114CSR43

WEST VIRGINIA 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 West Virginia Code § 33-25A-1 et seq.

1.2. Authority. -- W. Va. Code §§ 33-25A-3(3) 5, 20.

1.3. Filing Date. --

1.4. Effective Date. --

§ 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 West Virginia 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 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 they reside or have their 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 their 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 entry 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 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 such review shall be 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.

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 West Virginia 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 either:

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 such 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.

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 deems 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.

STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Legal Division

GASTON CAPERTON
Governor

HANLEY C. CLARK
Insurance Commissioner

July 31, 1995

HAND DELIVERED

RECEIVED
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OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

Ms. Judy Cooper, Director
Administrative Law Division
Office of Secretary of State
State Capitol
Charleston, West Virginia 25305

Dear Ms. Cooper:

Enclosed please find for filing one (1) copy of the following:

(1) Notice of Agency Approval of a Proposed Rule and Filing with the Legislative Rule-Making Review Committee;

(2) Fiscal Note;

(3) Consent to Proposed Rule;

(4) Brief Summary of the Rule;

(5) Statement of Circumstances;

(6) Legislative Rule-Making Review Committee Questionnaire; and

(7) The agency-approved rule entitled "Health Maintenance Organizations" (Series 43).

Please contact me if further information is required.

Very truly yours,

B. Keith Huffman

B. Keith Huffman
General Counsel

BKH/sar
Enclosures

2019 Washington Street, East
P.O. Box 50540
Charleston, West Virginia 25305-0540

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Attachment to Question 2(d)

A total of nine sets of comments were received to the proposed rule. These are addressed in two groups. Each of the first group was organized into section by section comments to the proposed rule. These were received respectively from: Alan L. Mytty, President and C.E.O. for Carelink; Lynne Fritter for the Health Insurance Association of America; Carl E. Callison, Corporate Planner for Mountain State Blue Cross/Blue Shield; and Sarah Nemecek for PrimeOne. The latter comment was filed after the end of the official comment period, but is addressed nonetheless.

Each of the second group of comments was organized in a narrative form and did not address specific sections of the proposed rule. Rather, this group of comments was more general and philosophical in nature. Each was very similar and obviously part of a collaborative effort by the respective authors. These were respectively, filed by: Steven J. Summer, President of the West Virginia Hospital Association; Robert L. Harmon, Administrator/CEO of Grant Memorial Hospital; Evelyn O'Brien, Coordinator of Southern Virginia's Rural Health Network; Robert E. Bryant, President of West Virginia EMS Coalition; and Andrew Mazon, III, Administrator/CEO of Roane General Hospital. A copy of all comments is attached.

Address of comments

The first group of comments are addressed on a section by section basis as follows:

Section 2 of the Proposed Rule

2.1.a. Mr. Mytty:

> 2.1.a. The definition of "Administrative health service contract" at paragraph 2.1.a. of the proposed rule include arrangements where payment is on a percentage of premium basis.

Department Response: While the list of payment methodologies in paragraph 2.1.a. is not exclusive, but by way of example only, Mr. Mytty's point is well taken and the staff has adopted his suggestion.

2.6. (Note: Because of renumbering with amendments, former 2.6 is now 2.7.)

Ms. Fritter:

> 2.6. Health Service Intermediary - This definition includes a provision which exempts providers directly contracting with a certificate of authority holder when that provider

renders those services directly. The Academy of Actuaries has noted that the requirement for a provider to "render services directly" could be subject to a 5 percent allowance for non-direct services. In many situations where a capitated rate is used, a few marginal services may not be provided directly by all providers, yet the HMO does not want to have to exclude those services given their marginal nature. The 5 percent figure allows this flexibility without exposure to gaming.

§ 114-43-2.6. Ms. Nemecek:

"Health service intermediary" or "intermediary": PrimeOne recommends substituting the name "Risk sharing provider" for "Health service intermediary." Risk sharing provider is the name generally used in the industry to describe this kind of entity. To avoid confusion and promote the uniform use of terms, PrimeOne suggests this substitution.

Department Response: Sub-section 2.6 does not prohibit or require the provider to exclude non-direct services as Ms. Fritter seems to suggest. It rather, subjects them to financial responsibility, reporting and quality standards as required by the proposed rule. In circumstances where a certificate of authority holder may be contracting out as high as ninety (90) percent or more of its premium stream, a five (5) percent allowance could amount to millions of dollars. There is no indication as to what the suggested five (5) percent is a measure of. Department staff believes that such a provision is unnecessary and would greatly complicate enforcement of the proposed rules by creating accounting issues, which could be difficult to resolve.

2.10. Note: Because of renumbering with amendments, former 2.10 is now 2.11.)

Ms. Fritter:

2.10. Qualified Independent Actuary - HIAA recommends the deletion of this definition and the elimination of all references to an "independent" actuary in the rule. The actuary is frequently doing primary work (i.e., not reviewing the work of others) and needs a far better understanding of the specifics of the organization to develop rates and reserves. The requirement of independence, therefore, could be a negative. The National Association of Insurance Commissioners ("NAIC") does not require independence in the actuary but relies on the actuarial profession standards to assure fair presentation. We would agree.

Department Response: See Department Response to subsection 3.1 below.

Section 3 of the Proposed Rule

3.1. Mr. Mytty:

3.1. If both the HMO and the health service intermediary are meeting the Department of Insurance regulations, then an opinion from an independent actuary only serves to increase costs and is unnecessary. Furthermore, an HMO and a health service intermediary may have long-range business and strategic reasons for contractual arrangements. To an independent actuary, those business goals may not be understood and there may be difficulty in getting an opinion on how financially sound the contract is. I propose that section 3.1 be amended by deleting the language after the word "commissioner".

Ms. Fritter:

Subsection 3.1 provides that the contract between the certificate of authority holder and the intermediary must be accompanied by an opinion which states that entering into the contract by the certificate holder is "financially sound." The term "financially sound" is not defined in the regulations and may be an ambiguous standard. Soundness relates to solvency which can be maintained even when the new arrangement is losing money, i.e. other areas of the business may be profitmaking. HIAA recommends that the term be changed to "financially reasonable."

Mr. Callison:

114C.S.R.§43-3.1. Intermediary Contract Requirements. Subsection 3.1 provides that 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 and is filed with the Commissioner accompanied by an opinion by a qualified independent actuary which states that entering into the contract by the certificate of authority holder is "financially sound." The term "financially sound" is not defined in the regulations and may not be a term with an industry accepted meaning. It, therefore, may be an ambiguous standard which should be defined in the regulations.

Ms. Nemecek:

114-43-3.1. PrimeOne recognizes the Insurance Commission's concern about the financial soundness of risk sharing agreements. However, the requirement of an opinion from a qualified independent actuary is unduly burdensome. Each of these opinions costs an estimated $5,000. Certificate of authority holders (COAHs) employ qualified actuaries who possess the skills and professional certifications necessary to certify the financial soundness of these agreements.

PrimeOne would like to distinguish this situation from a statutory requirement that a qualified independent actuary certify a COAH application and rates. The COAH's staff actuaries will review risk sharing arrangements without bias toward the provider and thus can assess the financial soundness objectively.

Department Response: W.Va. Code § 33-25A-7(b) requires that the Insurance Commissioner (Commissioner) monitor such contracts as to whether they are consistent with health care cost control. That section gives the Commissioner the power to require renegotiation or cancellation of the contract if not consistent with such concepts. W.Va. Code § 33-25A-4(2)(i) requires the Commissioner to review the "financial soundness" of the HMO's arrangements for health care services and approve them as a condition of the HMO's licensure. "Long range and strategic reasons" aside, the contracts must make financial sense for the HMO. An actuarial analysis of the financial impact of the contract on the HMO's business is the best vehicle to determine whether the contract is a financially sound business judgement. With respect to the issue of the independence of the actuary, the Department's past experience with in-house actuaries and other professionals is that they are often under a great deal of pressure from management to express opinions which best suit management's objectives. The use of independent actuaries gives an additional measure of protection that their opinion is not clouded by the fact that their whole livelihood rests on pleasing management. There is a large subjective element in any actuaries opinion and the extra measure of independence is wise. It is an overstatement that the NAIC never uses independent actuarial opinions. Any expenses associated with such opinion would necessarily be commensurate with the complexity and volume of business contracted out by the HMO and in comparison to the overall administrative expenses associated with that business would be minuscule. Staff therefore, elected to retain the language suggested for deletion or amendment by the commentators and to clarify the requirement by providing a definition of "financially sound" and "fiscally and financially sound" at a new sub-section 2.4 of the proposed rule. This new definition was adapted from the proposed Actuarial Opinion and Memorandum Rule 114CSR §43-7.2. and is consistent with terminology used by professional actuaries.

3.1.a. Mr. Mytty:

3.1.a. "I would hope that any reports between the health service intermediary and the HMO are private. To have reports become public will impede the ability of both the HMO and the health service intermediary to negotiate from a business standpoint. Simply put, if all reports and contracts are public, then the contracts are more likely to be identical. This makes pricing and contractual negotiations for both the provider organization and the HMO difficult and will decrease competition because the premiums

of the HMOs will tend to be the same".

Ms. Fritter:

Subsection 3.1(a) requires statutory accounting statements from the intermediary. since the intermediary is not otherwise required to do statutory accounting, and §14-43-5.1(c) provides that the guarantor of an intermediary is to provide generally accepted accounting principles (GAAP), we suggest that this subsection require GAAP statements from the intermediary.

Ms. Nemecek:

§114-43-3 a: This provision duplicates provisions noted below and needs additional consideration by the Insurance Commission. See also PrimeOne's comments for § 114-43-3f.

Department's Response: The reports required by paragraph 3.1.a. are from the intermediary to the HMO and not to the Insurance Commissioner. The Commissioner would have access to the reports under the examination powers given in W.Va. Code §§ 33-25A-17 and 33-2-9 and the report would be entitled to confidential treatment consistent with those sections until an examination is "filed" as a public document. Paragraph 3.1.a. of the proposed rule does nothing that would alter the confidentiality of documents possessed by the HMO, and as is explained in the Department's response to § 3.1 above, the Commissioner is required by statute to oversee the provider contracting and financial solvency of HMOs. The reports would be entitled to any of the relevant existing exemptions to the W. Va. Freedom of Information Act (W.Va. Code §§ 29B-1-1 et. seq.) including the "Trade secrets" exemption. Paragraph 3.1.a. is not duplicative, but rather, cumulative with subsequent provisions of the proposed rule. Nearly all insurance regulatory accounting is presented on a statutory accounting principles (SAP) basis, rather than a generally accepted accounting principle (GAAP) basis. Department staff believes that the intermediary statements should be presented consistently with the certificate of authority holders financial statements (i.e. SAP) since the intermediary is performing a portion of the certificate of authority holder's statutory responsibilities. In this way, when reconciling the financial statements of the certificate of authority holder and relevant intermediaries, the Department will be able to compare "apples to apples." The only reason subparagraph 5.1.c. permits (GAAP) financial statements is because it is asking for past and already prepared statements (i.e. already done on a GAAP basis). It would be a burden for the guarantor to have to convert such existing statements to a SAP basis.

3.1.b. Ms. Nemecek:

§144-43-3 b: PrimeOne recommends removing this

requirement. It is vague and duplicates other provisions of this proposal.

Department Response: The paragraph is neither duplicative, nor vague and was retained.

3.1.d. Mr. Mytty:

3.1.d. It is unreasonable to require a six-month reserve and a full month of funding for IBNR.

Ms. Fritter:

Subsection 3.1(d) requires the intermediary to maintain a certain working capital. This subsection is unclear. Are the assets to be one month's claims (based on the average for the most recent six months) or are they to be equal to six months of claims (based on the average of actual and estimated claims)? The NAIC has developed risk-based capital requirements for comparable insured coverages that are closer to two months of claims, unless the premium exceeds $50 million. HIAA suggests the NAIC approach.

Department's Response: Paragraph 3.1.d. of the proposed rule does not require a six-month reserve. It, rather, requires a one-month reserve, based upon a six-month average number. In the insurance/HMO industry one month of claims reserves is not at all an excessive financial cushion or margin of error. It is, in fact, very conservative. The NAIC has only begun to develop risk-based capital concepts for HMO's. They are far from complete. Department staff has reworded 3.1.d. to clarify that one months reserves are required.

3.1.e. Ms. Nemecek:

§ 144-43-3 e: PrimeOne recommends inserting "or an appropriate allocation when the entire monthly IBNR is not a credible standard" after "determined."

Department's Response: The suggested change would take a very reasonable objective standard and replace it with a completely subjective one which begs for dispute. The existing language was left intact.

3.1.e.A. Mr. Mytty:

3.1.A. (sic) I would hope that adequate language regarding hold harmless would also be sufficient for this paragraph and in meeting the capital and reserve fund requirements.

Department's Response: Paragraph 3.1.e.A of the proposed rule is a discretionary provision whereby the Commissioner may approve alternative methods of proving the financial soundness of an intermediary arrangement with an HMO. This section leaves to the

Commissioner's discretion whether to consider "hold harmless" language.

3.1.f. Mr. Mytty:

3.1.f. This language would appear to negate the contract between the certificate of authority holder and the health service intermediary. Questions would arise as to whether the intermediary could simply refuse to pay a claim. If a hold harmless clause is required, then this language should be unnecessary.

Ms. Fritter:

Subsection 3.1(f) requires the certificate of authority holder to assume the full financial responsibility for any valid claims presented for payment to the intermediary by providers for covered health care services to subscribers, et al. In essence, the certificate of authority holder is indemnifying providers under contract with an intermediary for any payments not received from the intermediary to the certificate holder. This requirement appears to exceed the statutory requirements contained in West Virginia Code § 33-25A. In particular, §7a(1) and (4) requires that the HMO rather than the subscriber is liable for the fees to the provider, and that the subscriber is not liable to the provider for any services covered by the subscriber's contract to the HMO. It does not provide that in a situation in which the provider has assumed part of the risk of providing services that the HMO should guarantee the obligation of the intermediary in the event of any nonpayment from the intermediary to the provider. The intermediary, assuming the risk, should be guaranteeing this payment.

Mr. Callison:

(Mr. Callison's comment is verbation with that of Mrs. Fritter.)

Ms. Nemecek:

§ 144-43-3 f: This provision is not consistent with § 144-43-4.2. As you know, each COHA is responsible for the benefits provided to its enrollees under West Virginia law. The assignment of risk and manner in which the COHA and the risk sharing provider account for that risk needs further consideration by the Insurance Commission.

Department's Response: The language does not negate the contract between the certificate of authority holder and the intermediary. The financial responsibility required by paragraph 3.1.f. is limited by the reference to "as in subsection 4.2 of

this rule" and therefore is completely consistent with 4.2. Subsection 4.2 limits the financial responsibility of the certificate of authority holder to valid claims other than claims of providers who have contracted with the intermediary. In this way the intermediary cannot simply overspend and then let the certificate of authority holder pay for the excess. The amounts the certificate of authority holder could potentially be held responsible for under paragraph 3.1.f and subsection 4.2 are covered services from providers other than those who have contracted with the intermediary. This is consumer protection provision to protect enrollees from being caught in the middle when an intermediary fails to live up to its contract. The Commissioner issues a certificate of authority to the certificate of authority holder (HMO), not the intermediary. It is the HMO that is responsible for living up to the prerequisites of that certificate including adequate provision of health care services. To the extent that the HMO contracts the responsibility for the provision of part, or most of, those health care services over to an unlicensed (and essentially unregulated) intermediary, the HMO cannot simply wash its hands of its responsibilities to its enrollees. The genesis of paragraph 3.1.f. and subsection 4.2 are actual experiences in other states where the HMO market is more mature than in West Virginia. The Commissioner's primary responsibility is the protection of the HMO enrollees and these provisions are designed to prevent the bad experiences in other states (eg. Florida). Health care intermediaries have frequently failed financially in those states and left enrollees with the onus of unpaid bills for providers services or the inability to obtain health care services. Paragraph 3.1.f. of the proposed rule is completely consistent with W. Va. Code §§ 33-25A(1) & (4). As two of the commentators note, those provisions require that the HMO retain financial responsibility and not the subscriber. That is exactly what paragraph 3.1.f does. W. Va. Code § 33-25A-4(2)(f) also requires that the HMO "assume full financial risk" (emphasis added). It is the opinion of the Department staff that hold harmless provisions do not alone adequately protect the consumer and that the language should remain unchanged.

3.1.h. Mr. Mytty:

3.1.h. This language should be the responsibility of the HMO. It should not be a burden placed upon a provider organization.

Ms. Fritter:

Subsection 3.1(h) should allow for an exception whereby the intermediary provides the services in an out-of-area or emergency situation.

Ms. Nemecek:

§ 144-43-3 h: PrimeOne recognized that enrollees need

access to network providers. However, this provision does not take into account the fact that COHAs contract with many providers that may not actually provide the service in the approved area of operation. For example, COHA's frequently use centers of excellence for transplants and other, tertiary care, and laboratories outside the COHAs counties of operation.

Department's Response: The department staff does not understand Mr. Mytty's comment. It is seemingly a misunderstanding of paragraph 3.1.h. Paragraph 3.1.h. simply requires that an intermediary cannot operate in a county in which the certificate of authority holder is not itself authorized to operate. Emergency and tertiary care are the responsibility of the certificate of authority holder and should be provided through direct provider contracts and reimbursement. (Direct contracts are "carved out" of this rule at paragraph 2.7.a. of the proposed rule). This rule should not therefore affect these services. Laboratory work performed outside the service area would not violate the rule so long as the samples were collected within the service area. The same procedure is now in effect as to lab work done directly for the certificate of authority holder and its direct providers. Department staff did not amend paragraph 3.1.h.

3.1.k. Ms. Nemecek:

144-43-3 k: PrimeOne recommends substituting "periodically" for "continuously."

Department's Response: Intermediary contracts set up ongoing and continuous business relationships between the certificate of authority holder and the intermediary which will involve daily transactions. The Department staff feel that "continuous" monitoring is more consistent with the reality of such contracts.

3.1.l. Ms. Nemecek:

144-43-3 l: PrimeOne recommends removing this provision because it duplicates statutory requirements.

Department's Response: Subparagraph 3.1.l. does reiterate statutory requirements that the certificate of authority holder must maintain certain financial criteria, but is necessary in the proposed rule to clarify that these requirements are not avoided by the entry of an intermediary contract.

3.1.m. Mr. Mytty:

3.1.m. Audited financial reports prepared by an independent certified public accountant should be unnecessary. The proposed language as written could potentially require that independent physicians, pharmacies, and any other provider would have to have an independent

audit. When providers are potentially contracting with several HMOs, this expense is both tremendous and unnecessary. I would hope that this requirement could be eliminated.

Ms. Fritter:

Subsection 3.1(m) requires the intermediary to provide its annual financial report to the HMO, which in turn files a copy of the report with the Commissioner. If the Commissioner retains jurisdiction over the intermediary, it is more expedient and less burdensome on the certificate holder if the intermediary is required to file the report directly to the Commissioner.

Mr. Callison:

114 C.S.R. § 43-3.1.m. Intermediary Contract Requirements. Subsection 3.1.m. requires the health service intermediary to provide an annual audited financial report tot he HMO on or by the first day of June each year. In turn, the certificate of authority holder is required to file a copy with the Commissioner. Since the Commissioner has jurisdiction over the intermediary, it would appear to be more expedient and put less of a burden on the certificate of authority holder if the intermediary were to file this annual report directly with the Commissioner rather than imposing this duty on the certificate of authority holder.

Ms. Nemecek:

114-43-3 m: PrimeOne suggest inserting "within ten days" after commissioner in the last sentence. § 144-43-4.8 should be removed because it duplicates this requirement.

Department's Response: Independent physicians, pharmacies, and other independent providers do not meet the definition of a "Health service intermediary" or "intermediary" as set out in subsection 2.7 of the proposed rule. The proposed rule, therefore, would not apply to them. Audited financial reports are required only of persons meeting the definition at subsection 2.7 and as to those persons the cost of the audit will be commensurate with the size (in terms of amount of business) and complexity of the intermediary contract. For example, an audit of an intermediary providing only very limited services in either volume or treatment areas would be a simple audit and not be of substantial expense. Once again, the certificate of authority holder (HMO), by entering an intermediary contract, is contracting out a part (and sometimes nearly all) of those activities which its certificate of authority permits it to legally do. The HMO must monitor these intermediaries for compliance with the original statutory requirements to maintain

an HMO certificate. Likewise, the Commissioner needs the financial data of the intermediaries to the same extent she or he needs the financial data of the HMO. Otherwise, a determination as to the solvency of the overall health care delivery system (HMO plus intermediaries) is impossible. The department does retain jurisdiction over the health service intermediary, but has much more control over the direct certificate of authority holder. Chapter thirty-three gives numerous specific remedies to the commissioner with regard to licensees. Control over the non-licensed intermediary is more tenuous and difficult to enforce. It is a minimal burden for the certificate of authority holder to forward the financial report to the Commissioner. The Department staff feels that a ten day period is reasonable and will incorporate it into the proposed rule at subsection 4.8. The last sentence of paragraph 3.1.m. is duplicative of subsection 4.8 and was deleted.

Section 4 of the Proposed Rule

4.1. Ms. Nemecek:

> § 114-43-4.1: PrimeOne recommends permitting COHAs to submit each contract within ten days of its execution. PrimeOne recommends striking all wording after "a full executed copy of the contract."

Department's Response: The language simply clarifies that all relevant attachments to the contract must be filed. The language was retained, however, a ten day filing period was adopted.

4.1.a.A. Ms. Fritter:

> Subsection 4.1.a.A. requires a certificate of authority holder to file an opinion of a qualified actuary regarding the contract between it and the intermediary. Chapter 25A does not require that such an opinion be rendered when the contract is filed, nor that such opinion be rendered by an actuary. Nevertheless, should this opinion be required, the word "sound" should be replaced by the word "reasonable" per our comments on § 114-43-3.1 above.

Mr. Callison:

> 114C.S.R.§ 43-4.1.a.A. HMO Requirements. The certificate of authority holder is required when filing a health service intermediary contract to file the opinion of a qualified independent actuary regarding the contract. Chapter 25A does not require that such an opinion be rendered when the contract is filed, nor that such opinion be rendered by an actuary. Nevertheless, if this opinion is to be required, the meaning of the term that this is a "fiscally and financially sound transaction" is not defined and, without definition or guidelines, may not be one upon which an actuary can opine.

Ms. Nemecek:

114-43-4.1.a: For the reasons stated above concerning § 114-43-3.1, PrimeOne again recommends that the COAH's actuary shall make this opinion.

Department's Response: See "Department Response" to comments to subsection 3.1. above.

4.2. Mr. Mytty:

4.2. "This language is confusing to me. It would imply that the HMO remains financially responsible for claims of providers not contracting with the intermediary. While generally this should be true, an HMO and a health services intermediary may agree in their contract that the intermediary is responsible for emergency service. Furthermore, the intermediary may be responsible for referrals for a certain esoteric services not directly available through the intermediary. This should be the option of the contracting parties to determine what services become the financial responsibility of the intermediary or the HMO".

Ms. Fritter:

Subsection 4.2 makes the certificate holder financially responsible for claims for covered services presented to the intermediary. Our comments on this provision are the same as those outlined in § 114-43-3.1.(f) above.

Mr. Callison:

114 C.S.R. § 43-4.2. HMO Requirements. Subsection 4.2 makes the certificate of authority holder financially responsible for any claims for covered health care services presented for payment to a health service intermediary and which are not paid by the health service intermediary. Our comments on this provision are the same as those contained in 2, hereinabove.

Ms. Nemecek:

114-43-4.2. Comments are noted above.

Department's Response: See Department Response to paragraph 3.1.f. of the proposed rule, above.

Ms. Nemecek:

114-43-4.3. This provision should be removed because it duplicates statutory requirements.

Department's Response: Statutory requirements do not

specifically discuss intermediary contracts and are not duplicated by subsection 4.3 of the proposed rule.

4.4. Ms. Fritter:

Subsection 4.4 requires the certificate holder to be responsible for the intermediary's compliance with all standards required by law. Should the Commissioner exercise his authority to directly regulate intermediaries, there is no reason to make the HMO reasonable and liable for the intermediary's non-compliance. Only the commissioner has the power and authority to bring the intermediary into compliance.

Mr. Callison:

114 C.S.R. § 43-4.4. HMO Requirements. This subsection requires the certificate of authority holder to be responsible for compliance by the health care intermediary with all applicable standards required by West Virginia Code § 33-25A. West Virginia Code § 33-25A-3(3) gives the Commissioner authority to regulate health care intermediaries. The Commissioner through this provision and others herein appears to be shifting this burden to the HMO, and, as such, would in essence place the full responsibility and potential liability of an intermediaries' noncompliance on the certificate of authority holder and absolve the intermediary in the event of any noncompliance. The HMO can only enforce these requirements against the intermediary through a legal action based on the contractual relationship, while the Commissioner has all the powers of his office, i.e., cease and desist orders, to bring about an immediate response from the intermediary.

Ms. Nemecek:

114-43-4.4. This provision is overly broad and should be limited to the hold harmless provision in the statute.

Department's Response: The Department has sought to achieve a balance between the competing interests of market flexibility and close regulatory control. As Ms. Nemecek points out in her letter "As the managed care market develops, it is important to recognize the financial implications of these developing relationships without placing burdensome requirements on the contracting entities which may deter further development of the market." The Commissioner is given the discretion to require full HMO licensure of the entities defined as intermediaries by the proposed rule. In order to permit licensed HMO's to enter into the intermediary contract, the Commissioner has elected not to require the intermediaries to become licensed as HMO's themselves. This would be administratively burdensome and stilt market development. The thrust of W. Va. Code §§ 33-25A-1 et. seq., however, is clearly toward focusing responsibility for

compliance with financial, quality and accessibility standards on the HMO which obtains a certificate of authority. The Commissioner has, therefore, elected to require the certificate of authority holder to retain a good measure of responsibility for the actions of those intermediaries performing functions which are necessary for the HMO to retain its certificate of authority. The Commissioner could prohibit the use of "Intermediaries," altogether, by requiring each to have their own HMO certificate of authority. As explained in a previous comment, the Commissioner has a much larger degree of control over an entity which must maintain a certificate from the Office of the Insurance Commissioner, as opposed to an unlicensed intermediary. The point overall is that the commentators appear to fluctuate between the extremes of a "no license" open market and a market where all risk bearing entities must be licensed. The rule establishes a reasonable balance.

4.6. Ms. Nemecek:

114-43-4.3. This provision should be removed because it duplicates statutory requirements.

Department's Response: While the requirements may be implicit in the statutes, statutory requirements do not specifically address accounting treatments of intermediary contract financial results and the subsection was retained to eliminate doubt and confusion.

4.7 Mr. Mytty:

4.7. I have great concern that by giving full access to all books and records to any health service intermediary and to any provider contracting with an intermediary that providers will be reluctant to contract if those records then become publicly available. These are private transactions between business entities and the examination should stop at the right to review the contract between the HMO and the intermediary. Furthermore, those contracts should not be publicly available because they are proprietary.

Ms. Fritter:

Subsection 4.7 requires the certificate holder to ensure that the Commissioner is give full access to all books and records of the intermediary, as well as becoming financially responsible for all costs associated with the examination of such books. HIAA suggests that the responsibility for making an examination of the books and the costs associated with such examination lie with the intermediary.

Mr. Callison:

114 C.S.R. § 43-4.7. HMO Requirements. The certificate of authority holder is responsible for insuring the

Commissioner is given full access to all books and records of any health service intermediary, and further is financially responsible for any costs of examining the books and records of the health service intermediary or subcontractor consistent with West Virginia Code § 33-2-9. The Commissioner shifts the financial responsibility for inspecting the financial records from the intermediary to the certificate of authority holder. It seems more appropriate that the costs incurred by any such inspection and the responsibility for making such an inspection should lie directly with the Commissioner and the intermediary and not through the certificate of authority holder. Likewise, the intermediary should bear the costs of this examination.

Ms. Nemecek:

114-43-4.7. This provision is overly broad and duplicates an earlier contract requirement. (§ 144-43-3 c). It is not possible for a COAH to "insure" this kind of access.

Department's Response: W.Va. Code §§ 33-25A-17(1) and (3) specifically require that the Commissioner be given full access to the books and records of both an HMO certificate of authority holder and providers with which it contracts. As noted in responses above, by not requiring intermediaries to obtain a certificate of authority most of the Commissioner's ability to regulate such entities devolves through the actual certificate of authority holder over which the Commissioner retains direct authority. The rules do not "shift" the responsibility for compliance with financial examination requirements to the certificate of authority holder. Rather, the rules maintain the responsibility with the direct licensee, instead of allowing the certificate of authority holder to contract such responsibility away. The only reason the intermediary can legally perform the relevant health care services is by way of the fact that it has a contract with the holder of a valid certificate of authority. It is logical that the Commissioner should look to the licensee which W. Va. Code § 33-25A-4(2)(f) says must "assume full financial responsibility" for the provision of health care services to facilitate access to the books and records of the intermediaries which the HMO elects to contract with. There is nothing to prevent the certificate of authority holder from recouping any costs from the intermediary via contract or otherwise. The Department staff concurs that the use of "insuring" access may be inappropriate and has revised the wording to "taking all reasonable measures to provide" access.

4.8. Ms. Nemecek:

114-43-4.8. Comments are noted above.

Department's Response: The Department staff adopted the previous comment with regard to "within ten days."

4.9. Mr. Mytty:

4.9. It is possible to immediately cancel an agreement, then what happens to the members of the HMO in that situation? I would hope that some reasonable judgement would apply and there would need to be some notice to the HMO and to the intermediary so that the terms of the contracts between the HMO and the employer group can be met.

Department's Response: Subsection 4.9 simply reiterates the requirements of W.Va. Code § 33-25A-7(b). Department staff is confident that the Commissioner will exercise reasonable judgment for the protection of the enrollees. Such actions of the Commissioners are subject to notice and hearing requirements (W.Va. Code §§ 33-25A-21, 29A-1-1 et seq.)

5.1.a. Ms. Fritter:

Subsection 5.1(a) contains an incomplete thought. It provides that an entity may fulfill an intermediary's obligations if it has a surplus on a West Virginia Statutory accounting basis of the greater of $2 million, without stating to what the $2 million is compared.

Mr. Callison:

114 C.S.R. § 43-5.1.a. Guarantees. The first sentence in subsection 5.1.a contains an incomplete thought. It provides that a health service intermediary's obligations which has been in operation for five years or more and has a surplus in West Virginia statutory accounting basis not including land, buildings and equipment, of the greater of "$2,000,000.00," without indicating what $2,000,000 is compared to.

Department's Response: The language was changed to "greater than $2,000,000."

6. Ms. Fritter:

The heading should read "severability" not "separability."

Mr. Callison:

114 C.S.R. § 43-6-6. The hearing in this section contains a typo. It should read "severability" and not "separability."

Department's Response: The terms severability and separability are synonymous and used interchangeably in rules and legislation.

The second group of comments, as noted above, are general in nature and do not address specific areas of the rules. These comments are very similar. The major points of this group of

comments can be characterized as follows:

1. That regulation should be different for traditional insurers as opposed to managed care type health care delivery systems;

2. That "Provider Sponsored Networks (PSN)" (Department note: essentially treated as health care intermediaries under the proposed rule) should either not be regulated at all or not regulated as an insurer or Health Maintenance Organization;

3. That PSNs should not be subject to financial surplus requirements; and

4. That PSNs should be permitted to use "hold-backs" or "capitation" instead of meeting financial surplus requirements.

Department Response: It is agreed that the regulation of traditional insurers should be accomplished differently that the regulation of managed care type insurance carriers. In West Virginia such managed care entities must generally be licensed as Health Maintenance Organizations under W.Va. Code §§ 33-25A-1 et seq. Health Maintenance Organizations are treated substantially differently than traditional insurers. They are "carved out" of many of the provisions of the W.Va. Code chapter 33 which relate to traditional insurers (see W.Va. Code §33-25A-24).

To the extent that it is suggested that PSN's or intermediaries should go unregulated, the Department must strongly disagree. Such position is not prudent, nor is it supported by W.Va. Code §§ 33-25A-1 et seq. Article 25A clearly requires that the Commissioner regulate the provider arrangements entered into by an HMO (see W.Va. Code §§ 33-25A-4(2)(c), 4(2)(d), 4(2)(f), 4(4), 7a and 18(1)(e). In fact, the Commissioner is given discretion to require licensure of any organization providing or arranging for the provision of health care services through certain payment methods (see W.Va. Code § 33-25A-3(3). It is especially important that the financial soundness of entities taking on the risk of providing health care services be regulated. It would be completely illogical to require stringent financial and quality criteria to be met by an HMO to achieve licensure and then to permit the HMO to contract away its responsibilities with no controls or checks on the contractors. The Department is aware of at least one proposed contract whereby an HMO would surrender ninety percent (90%) of its financial risk to an unlicensed intermediary.

The Department agrees however, that flexibility should be given to an HMO in entering provider contracts so long as financial responsibility, quality and access of care are safeguarded. For this reason subparagraph 3.1.e.A. of the proposed rule allows the Commissioner to approve alternative financial arrangements.

For the above reasons the Department believes that the proposed rule achieves both flexibility in contracting and protection of the consumer. The rule only intrudes into the contracting arrangement to the extent necessary to be certain that the original criteria upon which the certificate of authority was granted to the HMO are still met when performed by intermediaries.

Department Note: Department staff upon further consideration of the proposed rule became concerned that the regulatory requirements may be evaded by the use of intermediary sub-contracts. That is that the intermediary contract with the certificate of authority holder could be used as a "shell" with all work actually performed by a sub-intermediary. For this reason, the staff amended section 2.1 and subsection 2.1.a to include arrangements between intermediaries. The intermediaries regulated by the proposed rule are still only those providing health care services to enrollees of the certificate of authority holder, but whether directly or indirectly (see section 2.7 of the proposed rule defining "health service intermediary").

WVHA
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July 27, 1995

Hanley C. Clark
Insurance Commission
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Dear Mr. Clark:

The West Virginia Hospital Association would like to respond to the recent proposed regulations governing health service intermediaries, West Virginia Code Section 33-25A-3(3), e, and 20 as filed with the Secretary of State on June 28, 1995. We request the following comments be considered in preparing the final regulations. Specifically, WVHA is opposed to the promulgation of rules which would restrict the development of an integrated delivery system in West Virginia by eliminating the option of a risk sharing arrangement between health benefit plans and Provider Sponsored Networks (PSN).

INTRODUCTION

The West Virginia Hospital Association supports the development of an integrated delivery system, however, regulatory impediments under proposed insurance commission rules may impede the ability of providers to develop networks and assume risk under capitation or pre-payment. Our goals with respect to advocacy for appropriate regulation of provider based health plans and risk-bearing entities are:

- To ensure the ability of provider based networks to form and accept capitated and incentive based payments from health plans without themselves also being regulated as a health plan. Regulations should not require deplicative regulation of health plans and the provider entities which contract with them.

- To remove regulatory barriers for provider based entities to become or sponsor health plans themselves and to remove barriers for provider based entities entering the market which are not grounded in public protection.

- To advocate for health plan standards that support public accountability and the delivery of high quality coordinated care. Standards should appropriately separate health plan and provider functions.

- To ensure that health plan requirements applied to integrated delivery systems

appropriately reflect the operating and risk differences between health plans that predominately pay claims and health plans that predominately produce health services. The two types of plans are different in the way they experience and manage risk, and the way they protect against insolvency.

BACKGROUND

Provider Sponsored Networks (PSN), such as PHOs, integrated service networks, and other provider based networks are formal affiliations of providers, organized and operated to provide an integrated network of health care providers with which third parties, such as insurance companies, HMOs or other Health Plan Companies, may contract for the provision of health care services to covered individuals.

Provider Sponsored Networks do have several things in common. In general, they are initiated, financed, and governed by health care providers. They generally are formed for the purpose of delivering health care services through contracts with Health Plan Companies. The PSN often will arrange to contract on an accountable basis, using techniques such as capitation or "hold backs," and they generally will subject themselves to internal quality assurance, utilization review, and credentialing standards.

Provider Sponsored Networks play an important and positive role in health care delivery, particularly in the delivery of managed health care. Health plans have found that the expansion of programs of managed care is facilitated by PSNs, as they:

- provide an established network of providers;
- promote provider accountability for quality by providing a vehicle through which administrative simplification and clinical quality management programs can be implemented; and,
- reduce the health plan's administrative expense of contracting by providing a single party through which to negotiate contract terms.

Traditional Health Plan Company Type Regulation of PSN is Redundant and Does Not Serve a Useful Public Purpose.

Provider Sponsored Networks differ significantly from Health Plan Companies. For example, PSNs:

- do not contract directly with covered persons;
- are not the focus of plan design, premium or rate setting, or benefit administration; and,

- are primarily in the business of providing health care services directly or through their affiliates rather than in the business of insurance.

These differences are highly significant. A group of hospitals and physicians, for example, does not dictate to a Health Plan Company the type and extent of benefits to be offered to employers and employees. Similarly, while providers obviously negotiate the charges for their services with a Health Plan Company, the providers have no direct say in establishing the premium the Health Plan Company would, in turn, charge to employers. Moreover, a group of hospitals and physicians in City A would have no say over which providers would be a part of the Health Plan Company's network in City B (nor would the City A providers have any ability to oversee the quality of care in City B). Each of those differences reflect the fact that the business of PSN (delivering health care services) is *not* the same as the business of a Health Plan Company (extending commitments of health care coverage).

Health Plan Companies sometimes pay PSN on a capitated basis or in a similar way which reflects an incentive to manage health care service delivery within a budgeted amount. Some suggest that PSN should be subject to Health Plan Company-type regulation, particularly solvency regulation. This argument is often premised on the notion that a capitated or similar performance-based payment is the economic equivalent of a premium. Reasoning backwards, proponents of this line of thought conclude that since the PSN is receiving a "premium," it must be a Health Plan Company, and if it is a Health Plan Company, it should be subject to the same solvency, filing, and reporting requirements applicable to Health Plan Companies in general. This argument is often advanced with the intent of "creating a level playing field," but thereby ignoring the fact that PSN and Health Plan Companies are fundamentally different in operation, in purpose, and in the eyes of consumers and purchasers, regardless of how one might characterize payment methodologies.

Historically, PSN insurance regulation has sought to promote four public policy goals: *solvency* of the insurer (to protect consumers' expectations that coverage is there when they need it); *fairness* in claim payment (to protect consumers from corporate overreaching): *adequacy* of the benefit package (to protect consumers from misleading sales claims or "junk" coverage); and overall honesty and *competency* of company management and operations (to serve as a buffer and a bulwark for all of the foregoing). The WVHA agrees that these must continue to be important considerations in Health Plan Company regulation.

There are several critical reasons why traditional Health Plan Company type regulation is not relevant to PSN operations, primarily because many of the historic public policy goals of insurance regulation are obviously not applicable to PSN.

- Assurance of adequate benefit design, while an important and necessary goal, is not achieved through PSN regulation since the PSN has very little if anything to do with designing a plan of benefits. PSN provide health care services, not health plan benefits. It is the insurer, HMO or employer which generally selects the benefits to be provided and then in turn contracts with groups of providers to

deliver covered services.

- Assurance of fair benefit payment is quite important to health care providers, since they are often the ultimate economic beneficiaries of those payments. What provider of service is not interested in receiving payment for the services which a health insurance policy is intended to cover? However, it would be inherently circular to impose insurance type regulation on PSN simply to assure that the PSN pays itself and its members in a fair and consistent way.

- Competent and honest administration have equal applicability to health care providers and Health Plan Companies, but those goals have been historically well advanced at the provider level through existing state licensure requirements and oversight directed at physicians, hospitals, and other professional care givers. One might well argue that the jurisdiction and disciplinary authority of any state professional licensing board over health care professionals and of state health departments over institutional providers exceeds to a significant degree the type of control exercised by state insurance regulators over health plan managers, officers or directors.

- Provides little opportunity for PSN to mislead the public. Consumers will look first to the entity which has given them a direct promise of coverage, rather than health care providers, to resolve issues regarding their health coverage.

Provider based entities must have the flexibility to assume risk for delivery of services through capitation without being subject to capitalization reserve requirements and other regulation. By applying insurance regulations to provider entities, capital will be unnecessarily diverted from health care delivery purposes. Thus, many provider entities, and the communities they serve, unable to organize their own managed care products, would be at great disadvantage in the marketplace. Furthermore, the development of provider based managed care plans may serve to reduce or eliminate some of limited health care resources which now go towards HMO overhead and profits.

The West Virginia Hospital Association encourages the Department of Insurance to help facilitate delivery system reform by removing any obstacles for the transition of networks, PHOs, and other provider based managed care entities. We believe these regulations, if modified to accommodate these changes represents a step in that direction.

Sincerely,

Steven J. Summer

Steven J. Summer
President

HIAA
Health Insurance Association of America

July 28, 1995

B. Keith Huffman
General Counsel
West Virginia Insurance Commission
P.O. Box 0540
2019 Washington Street, East
Charleston, WV 25305-0540

Re: Rule Series 43 -- HMOs

Dear Mr. Huffman:

The Health Insurance Association of America ("HIAA") is pleased to submit these comments with regard to the above-mentioned rule. We have both general and specific comments, and each are outlined below.

Generally, HIAA supports reasonable regulation of HMOs and any currently unregulated entity attempting to conduct the business of insurance without a license and without complying with insurance regulations. If the intent of Series 43 is to rein in unregulated intermediaries, we would concur with including them in the regulation. On the other hand if the Department has full regulatory power over the certificate holder, with whom the intermediary must contract, there doesn't seem to be a need to regulate or control intermediaries, specifically with regard to their financial stability.

HIAA offers the following technical comments:

§114-43-2 Definitions

2.6 - **Health Service Intermediary** - This definition includes a provision which exempts providers directly contracting with a certificate of authority holder when that provider renders those services directly. The Academy of Actuaries has noted that the requirement for a provider to "render services directly" could be subject to a 5 percent allowance for non-direct services. In many situations where a capitated rate is used, a few marginal services may not be provided

directly by all providers, yet the HMO does not want to have to exclude those services given their marginal nature. The 5 percent figure allows this flexibility without exposure to gaming.

2.10. - Qualified Independent Actuary - HIAA recommends the deletion of this definition and the elimination of all references to an "independent" actuary in the rule. The actuary is frequently doing primary work (i.e., not reviewing the work of others) and needs a far better understanding of the specifics of the organization to develop rates and reserves. The requirement of independence, therefore, could be a negative. The National Association of Insurance Commissioners ("NAIC") does not require independence in the actuary but relies on the actuarial profession standards to assure fair presentation. We would agree.

§114-43-3. - Intermediary Contract Requirements

Subsection 3.1 provides that the contract between the certificate of authority holder and the intermediary must be accompanied by an opinion which states that entering into the contract by the certificate holder is "financially sound." The term "financially sound" is not defined in the regulations and may be an ambiguous standard. Soundness relates to solvency which can be maintained even when the new arrangement is losing money, i.e. other areas of the business may be profitmaking. HIAA recommends that the term be changed to "financially reasonable."

Subsection 3.1(a) requires statutory accounting statements from the intermediary. Since the intermediary is not otherwise required to do statutory accounting, and §114-43-5.1(c) provides that the guarantor of an intermediary is to provide generally accepted accounting principles (GAAP), we suggest that this subsection require GAAP statements from the intermediary.

Subsection 3.1(d) requires the intermediary to maintain a certain working capital. This subsection is unclear. Are the assets to be one month's claims (based on the average for the most recent six months) or are they to be equal to six months of claims (based on the average of actual and estimated claims)? The NAIC has developed risk-based capital requirements for comparable insured coverages that are closer to two months of claims, unless the premium exceeds $50 million. HIAA suggests the NAIC approach.

Subsection 3.1(f) requires the certificate of authority holder to assume the full financial responsibility for any valid claims presented for payment to the intermediary by providers for covered health care services to subscribers, et al. In essence, the certificate of authority holder is indemnifying providers under contract with an intermediary for any payments not received from the intermediary to the certificate holder. This requirement appears to exceed the statutory requirements contained in West Virginia Code §33-25A. In particular, §7a(1) and (4) requires that the HMO rather than the subscriber is liable for the fees to the provider, and that the subscriber is not liable to the provider for any services covered by the subscriber's contract to the HMO. It does not provide that in a situation in which the provider has assumed part of the risk of providing services that the HMO should guarantee the obligation of the intermediary in the event of any nonpayment from the intermediary to the provider. The intermediary, assuming the risk, should be guaranteeing this payment.

Subsection 3.1(h) should allow for an exception whereby the intermediary provides the services in an out-of-area or emergency situation.

Subsection 3.1(m) requires the intermediary to provide its annual financial report to the HMO, which in turn files a copy of the report with the Commissioner. If the Commissioner retains jurisdiction over the intermediary, it is more expedient and less burdensome on the certificate holder if the intermediary is required to file the report directly with the Commissioner.

§114-43-4. HMO Requirements

Subsection 4.1.a.A. requires a certificate holder to file an opinion of a qualified actuary regarding the contract between it and the intermediary. Chapter 25A does not require that such an opinion be rendered when the contract is filed, nor that such opinion be rendered by an actuary. Nevertheless, should this opinion be required, the word "sound" should be replaced by the word "reasonable" per our comments on §114-43-3.1 above.

Subsection 4.2 makes the certificate holder financially responsible for claims for covered services presented to the intermediary. Our comments on this provision are the same as those outlined in §114-43-3.1.(f) above.

Subsection 4.4. requires the certificate holder to be responsible for the intermediary's compliance with all standards required by law. Should the Commissioner exercise his authority to directly regulate intermediaries, there is no reason to make the HMO responsible and liable for the intermediary's non-compliance. Only the Commissioner has the power and authority to bring the intermediary into compliance.

Subsection 4.7 requires the certificate holder to ensure that the Commissioner is give full access to all books and records of the intermediary, as well as becoming financially responsible for all costs associated with the examination of such books. HIAA suggests that the responsibility for making an examination of the books and the costs associated with such examination lie with the intermediary.

§114-43-5, Guarantees

Subsection 5.1(a) contains an incomplete thought. It provides that an entity may fulfill an intermediary's obligations if it has a surplus on a West Virginia Statutory accounting basis of the greater of $2 million, without stating to what the $2 million is compared.

§114-43-6, Severability

The heading should read "severability" not "separability."

HIAA appreciates the opportunity to comment on this regulation. If you have any questions please feel free to call me at (202) 824-1713.

Sincerely,

Lynne C. Fritter

Lynne Fritter
Counsel

cc: Randy Cox

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BlueCross BlueShield

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JUL 2 1995
LEGAL DIVISION
W. VA. INS. DEPT.

July 28, 1995

Hanley Clark
Insurance Commissioner
2019 Washington Street, East
Charleston, West Virginia 25311

Dear Mr. Clark:

Attached are comments to proposed Title 114, Series 46, dealing with filing procedures for health maintenance organizations and proposed Title 114, Series 43, dealing with health maintenance organizations and, in particular, intermediary contract requirements. Your consideration of these comments is appreciated.

Sincerely,

Carl E. Callison
Corporate Planner

COMMENTS ON TITLE 114, SERIES 43, HEALTH MAINTENANCE ORGANIZATIONS:

1. 114 C.S.R. § 43-3.1. Intermediary Contract Requirements. Subsection 3.1 provides that 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 and is filed with the Commissioner accompanied by an opinion by a qualified independent actuary which states that entering into the contract by the certificate of authority holder is "financially sound." The term "financially sound" is not defined in the regulations and may not be a term with an industry accepted meaning. It, therefore, may be an ambiguous standard which should be defined in the regulations.

2. 114 C.S.R. § 43-3.1.f. Intermediary Contract Requirements. Subsection 3.1.f requires the certificate of authority holder to assume the full financial responsibility for any valid claims presented for payment to the intermediary by providers for covered health care services to subscribers, et al. In essence, the certificate of authority holder is indemnifying providers under contract with an intermediary for any payments not received from the intermediary to the certificate of authority holder. This requirement appears to exceed the statutory requirements contained in West Virginia Code § 33-25A. In particular, § 7a(1) and (4) requires that the HMO rather than the subscriber is liable for the fees to the provider, and that the subscriber is not liable to the provider for any services covered by the subscriber's contract to the HMO. It does not provide that in a situation in which the provider has assumed part of the risk of providing services that the HMO should guarantee the obligations of the intermediary in the event of any nonpayment from the intermediary to the provider. The intermediary, assuming the risk, should be guaranteeing this payment.

3. 114 C.S.R. § 43-3.1.m. Intermediary Contract Requirements. Subsection 3.1.m. requires the health service intermediary to provide an annual audited financial report to the HMO on or by the first day of June each year. In turn, the certificate of authority holder is required to file a copy with the Commissioner. Since the Commissioner has jurisdiction over the intermediary, it would appear to be more expedient and put less of a burden on the certificate of authority holder if the intermediary were to file this annual report directly with the Commissioner rather than imposing this duty on the certificate of authority holder.

4. 114 C.S.R. § 43-4.1.a.A. HMO Requirements. The certificate of authority holder is required when filing a health service intermediary contract to file the opinion of a qualified independent actuary regarding the contract. Chapter 25A does not require that such an opinion be rendered when the contract is filed, nor that such opinion be rendered by an actuary. Nevertheless, if this opinion is to be required, the meaning of the term that this is a "fiscally and financially sound transaction" is not defined and, without definition or guidelines, may not be one upon which an actuary can opine.

5. 114 C.S.R § 43-4.2. HMO Requirements. Subsection 4.2 makes the certificate of authority holder financially responsible for any claims for covered health care services presented for payment to a health service intermediary and which are not paid by the health service intermediary. Our comments on this provision are the same as those contained in 2. hereinabove.

6. 114 C.S.R. § 43-4.4. HMO Requirement. This subsection requires the certificate of authority holder to be responsible for compliance by the health care

intermediary with all applicable standards required by West Virginia Code § 33-25A. West Virginia Code § 33-25A-3(3) gives the Commissioner authority to regulate health care intermediaries. The Commissioner through this provision and others herein appears to be shifting this burden to the HMO, and, as such, would in essence place the full responsibility and potential liability of an intermediaries' noncompliance on the certificate of authority holder and absolve the intermediary in the event of any noncompliance. The HMO can only enforce these requirements against the intermediary through a legal action based on the contractual relationship, while the Commissioner has all the powers of his office, i.e., cease and desist orders, to bring about an immediate response from the intermediary.

7. 114 C.S.R. § 43.4.7. HMO Requirements. The certificate of authority holder is responsible for insuring that the Commissioner is given full access to all books and records of any health service intermediary, and further is financially responsible for any costs of examining the books and records of the health service intermediary or subcontractor consistent with W. Va. Code § 33-2-9. The Commissioner shifts the financial responsibility for inspecting the financial records from the intermediary to the certificate of authority holder. It seems more appropriate that the costs incurred by any such inspection and the responsibility for making such an inspection should lie directly with the Commissioner and the intermediary and not through the certificate of authority holder. Likewise, the intermediary should bear the costs of this examination.

8. 114 C.S.R. § 43-5.1.a. Guarantees. The first sentence in subsection 5.1.a contains an incomplete thought. It provides that a health service intermediary's obligations which has been in operation for five years or more and has a surplus in West

Virginia statutory accounting basis not including land, buildings and equipment, of the greater of "$2,000,000.00," without indicating what $2,000,000 is compared to.

9. 114 C.S.R. § 43-6.6. The heading in this section contains a typo. It should read "severability" and not "separability."

Copy

Facsimile Cover Sheet

Anthem Benefit Services, Inc.
Legal Department - 4th Floor
4040 Vincennes Circle
Indianapolis, Indiana 46268

To: Mr. Keith Huffman
Company: West Virginia Insurance Commission
Phone: 304/558-0401
Fax: 304/558-0412

From: Sarah Nemecek
Company: Anthem Health
Phone: 317-228-7433
Fax: 317-228-7482

Date: 07/28/95
Pages including this cover page: 4

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Comments:

PRIMEONE
An Anthem Health Plan

P. O. Box 1109
Charleston, West Virginia 25324
1-800-607-7461

July 28, 1995

Mr. Keith Huffman
General Counsel
West Virginia Insurance Commission
P.O. Box 0540
2019 Washington Street, East
Charleston, West Virginia 25305-0540

Subject: Rule Series 46 and Rule Series 43

Dear Mr. Huffman:

Thank you for this opportunity to provide the Insurance Commission with comments on the above captioned proposed rules. PrimeOne is a health maintenance organization which was licensed by the Insurance Commission in 1994. Unfortunately PrimeOne only received the proposed rules earlier this week. Due to the short time period PrimeOne has had to consider these proposals, I would like to begin my comments with an invitation to meet with representatives of the Insurance Commission to further discuss these proposals and PrimeOne's comments.

Comments on each proposal will be addressed separately beginning with Rule Series 46, HMO filing procedures:

PrimeOne would like to compliment the Insurance Commission for proposing rules that include forms addressing the requirements for licensure and for annual financial and grievance procedure reports. These forms will streamline the application and reporting process for carriers and reduce the Insurance Commission's administrative burden. PrimeOne recommends removing the portions of this proposed rule that duplicate the HMO statute. Restating the statutory requirements in this regulation will only cause confusion and could lead to minor inconsistencies between the statute and regulation. Removing these portions will leave carriers with the tools necessary to comply with statutory requirements.

Comments on Rule Series 43, Health Care Intermediary, will be addressed section by section. In general, PrimeOne would like to complement the West Virginia as one of the few states having the foresight to regulate risk sharing arrangements without requiring providers to become licensed. As the managed care market develops, it is important to recognize the financial implications of these developing relationships without placing burdensome requirements on the contracting entities which may deter further development of the market.

§ 114-43-2.6, "Health service intermediary" or "intermediary": PrimeOne recommends substituting the name "Risk sharing provider" for "Health service intermediary." Risk sharing provider is the name generally used in the industry to describe this kind of entity. To avoid confusion and promote the uniform use of terms, PrimeOne suggests this substitution.

§ 114-43-3.1: PrimeOne recognizes the Insurance Commission's concern about the financial soundness of risk sharing agreements. However, the requirement of an opinion from a qualified independent actuary is unduly burdensome. Each of these opinions costs an estimated $5,000. Certificate of authority holders (COAHs) employ qualified actuaries who possess the skills and professional certifications necessary to certify the financial soundness of these agreements. PrimeOne would like to distinguish this situation from the statutory requirement that a qualified independent actuary certify a COAH application and rates. The COAH's staff actuaries will review risk sharing arrangements without bias toward the provider and thus can assess the financial soundness objectively.

§ 144-43-3 a: This provision duplicates provisions noted below and needs additional consideration by the Insurance Commission. See also PrimeOne's comments for § 144-43-3 f.

§ 144-43-3 b: PrimeOne recommends removing this requirement. It is vague and duplicates other provisions of this proposal.

§ 144-43-3 e: PrimeOne recommends inserting "or an appropriate allocation when the entire monthly IBNR is not a credible standard" after "determined."

§ 144-43-3 f: This provision is not consistent with § 144-43-4.2. As you know, each COHA is responsible for the benefits provided to its enrollees under West Virginia law. The assignment of risk and manner in which the COHA and the risk sharing provider account for that risk needs further consideration by the Insurance Commission.

§ 144-43-3 h: PrimeOne recognized that enrollees need access to network providers. However, this provision does not take into account the fact that COHAs contract with many providers that may not actually provide the service in the approved area of operation. For example, COHA's frequently use centers of excellence for transplants and other, tertiary care, and laboratories outside the COHAs counties of operation.

§ 144-43-3 k: PrimeOne recommends substituting "periodically" for "continuously."

§ 144-43-3 l: PrimeOne recommends removing this provision because it duplicates statutory requirements.

§ 144-43-3 m: PrimeOne suggest inserting "within ten days" after commissioner in the last sentence. § 144-43-4.8 should be removed because it duplicates this requirement.

§ 144-43-4.1: PrimeOne recommends permitting COHAs to submit each contract within ten days of its execution. PrimeOne recommends striking all wording after "a full executed copy of the contract."

§ 144-43-4.1 a: For the reasons stated above concerning § 114-43-3.1, PrimeOne again recommends that the COAH's actuary shall make this opinion.

§ 114-43-4.2: Comments are noted above.

§ 114-43-4.3: This provision should be removed because it duplicates statutory requirements.

§ 114-43-4.4: This provision is overly broad and should be limited to the hold harmless provision in the statute.

§ 114-43-4.6: This provision should be removed because it duplicates statutory requirements.

§ 114-43-4.7: This provision is overly broad and duplicates an earlier contract requirement. (§ 144-43-3 c). It is not possible for a COAH to "insure" this kind of access.

§ 144-43-4.8: Comments are noted above.

Thank you again for this opportunity to comment on these proposed rules. Please call me if you desire additional information or have any questions.

Very truly yours,

Sarah Nemecek

GAYE B. MITCHELL
PRESIDENT

ROBERT L. HARMAN
ADMINISTRATOR

REGIONAL HEALTH CARE CENTER
P.O. BOX 1019
PETERSBURG, WV 26847

(304) 257-1026
FAX (304) 257-2537

July 28, 1995

Hanley C. Clark, Insurance Commissioner
2019 Washington Street, East
P. O. Box 50540
Charleston, WV 25305-0540

Dear Mr. Clark:

I am writing to respond to the recent proposed regulations for Health Maintenance Organizations, WV Code Section 32-25A-3 (3), e, and 20 which were filed by the Secretary of State on June 28, 1995. I am requesting that the comments be considered during your preparation of the final regulations. I am opposed to the promulgation of regulations that eliminate or severely restrict in any form the option of a risk sharing arrangement between integrated delivery networks and health benefit plans.

In response to the advent of managed care within this State, there has been a variety of activities undertaken by providers to develop integrated delivery networks. Some of these networks are anchored by large institutions while others have a base of small institutional providers. In any case, the intent is to develop a more efficient and effective system within the State. These networks will have the authority to deliver a broad range of integrated services including physician services that may be directly provided by the network members or contracted from outside resources.

Networks intent to ensure access to care for citizens residing within their area and will promote a high degree of accountability for the quality of services that they provide.

Integrated delivery system networks in order to be effective must be able to have some degree of flexibility in dealing with risk assumption. These organizations must be able to assume some risk for the delivery of the services that they provide through

capitation without being subject to reserve requirements and other regulations. By applying insurance regulations to these provider organizations, you thereby restrict their ability to effectively control local costs and divert capital away from the actual delivery of services.

I sincerely hope that the final regulations are in line with permitting these organizations to develop and flourish within the State. They have great promise for integrating services within rural areas.

Sincerely yours,

GRANT MEMORIAL HOSPITAL

Robert L. Harman
Administrator/CEO

RLH:mlh

GAYE B. MITCHELL
PRESIDENT

ROBERT L. HARMAN
ADMINISTRATOR

REGIONAL HEALTH CARE CENTER
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July 28, 1995

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Sincerely yours,

GRANT MEMORIAL HOSPITAL

Robert L. Harman
Administrator/CEO

RLH:mlh

SOUTHERN VIRGINIAS RURAL HEALTH NETWORK
ROUTE 2, BOX 382
BLUEFIELD, WV 24701
(304) 325-3621 (304) 425-9511

July 28, 1995

Mr. Hanley C. Clark
Insurance Commission
2019 Washington Street, East
P. O. Box 50540
Charleston, WV 25305-0540

Reference: WV Code Section 33-25A-3 and 20

Dear Mr. Clark:

The Southern Virginias Rural Health Network is one of the demonstration projects funded by the Benedum Foundation and Robert J. Wood Foundation. This network is comprised of Bluefield Regional Medical Center, Mercer Health Center and Appalachian OH-9 Emergency Medical Services and Home Care serving the rural population of Mercer and surrounding counties. We oppose the rules that would restrict the development of an integrated delivery system by eliminating the option of a risk sharing arrangement between health plans and provider networks.

Community provider based networks need to be able to form and accept capitation without being regulated as a health plan. Regulations should not require duplicate regulation of health plans and the provider entities which contract with them.

Community provider based integrated delivery systems (networks) need to be able to sponsor health plans themselves. Barriers to this, not grounded in public protection, need to be removed.

Community provider based integrated delivery systems should be permitted to contract directly with state and private purchasers of health care.

Integrated community provider delivery systems should not be regulated in the same manner as HMOs, as they primarily provide health services and are not claims paying entities, and thus, do not have the same needs with regard to financial solvency.

In summary, we encourage the Insurance Commission to create a policy environment in West Virginia that facilitates the development of community provider based integrated delivery systems that meets the health care needs of our rural communities.

Sincerely,

Evelyn O'Brien

Evelyn O'Brien
Coordinator

SOUTHERN VIRGINIAS RURAL HEALTH NETWORK
ROUTE 2, BOX 382
BLUEFIELD, WV 24701
(304) 325-3621 (304) 425-9511

July 28, 1995

Mr. Hanley C. Clark
Insurance Commission
2019 Washington Street, East
P. O. Box 50540
Charleston, WV 25305-0540

Reference: WV Code Section 33-25A-3 and 20

Dear Mr. Clark:

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In summary, we encourage the Insurance Commission to create a policy environment in West Virginia that facilitates the development of community provider based integrated delivery systems that meets the health care needs of our rural communities.

Sincerely,

Evelyn O'Brien

Evelyn O'Brien
Coordinator

WEST VIRGINIA EMS COALITION

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JUL 2 8 1995

WEST VIRGINIA
INSURANCE COMMISSION

July 26, 1995

Hanley C. Clark
Insurance Commission
2019 Washington Street, East
P.O. Box 50540
Charleston, West Virginia 25305-0540

Dear Mr. Clark:

The West Virginia EMS Coalition would like to respond to the recently proposed regulations governing health service intermediaries, West Virginia Code Section 33-25A-3 and 20 as filed with the Secretary of State on June 28, 1995. We request the following comments be considered in preparing the final regulations. Specifically, West Virginia EMS Coalition is opposed to the promulgation of rules which would restrict development of an integrated delivery system in West Virginia by eliminating the option of a risk sharing arrangement between health benefit plans and provider networks.

The West Virginia EMS Coalition supports the development of an integrated delivery system through network development, however, regulatory impediments under proposed insurance commission rules may impede the ability of providers to develop networks and assume risk under capitation of pre-payment. Our goals with respect to advocacy for appropriate regulation of provider based health plans and risk-bearing entities are:

* To ensure the ability of provider based networks to form and accept capitated and incentive based payments from health plans without themselves also being regulated as a health plan. Regulations should not require duplicative regulation of health plans and the provider entities which contract with them.

* To remove regulatory barriers for provider based entities to become or sponsor health plans themselves and to remove barriers for provider based entities entering

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the market which are not grounded in public protection.

* *To advocate for health plan standards that support public accountability and the delivery of high quality coordinated care. Standards should appropriately separate health plan and provider functions.*

* *To ensure that health plan requirements applied to integrated delivery systems appropriately reflect the operating and risk differences between health plans that predominately pay claims and health plans that predominately produce health services. The two types of plans are different in the way they experience and manage risk, and the way they protect against insolvency.*

Provider networks developing in West Virginia, including the four Rural Demonstration networks, will be denied the ability to do business with purchasers of health care, including Medicaid, Medicare, and PEIA, if these regulations are adopted. These developing networks cannot be regulated in the same way that HMOs are with respect to financial solvency requirements, since these are not claims paying entities.

The West Virginia EMS Coalition encourages the Department of Insurance to help facilitate delivery system reform by removing any obstacles for the development of provider based networks and to encourage new models of health care delivery.

Sincerely,

Roger E. Bryant

Roger E. Bryant,
President

RB/ldb

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WEST VIRGINIA EMS COALITION

RECEIVED
JUL 2 8 1995
WEST VIRGINIA
INSURANCE COMMISSION

July 26, 1995

Hanley C. Clark
Insurance Commission
2019 Washington Street, East
P.O. Box 50540
Charleston, West Virginia 25305-0540

Dear Mr. Clark:

The West Virginia EMS Coalition would like to respond to the recently proposed regulations governing health service intermediaries, West Virginia Code Section 33-25A-3 and 20 as filed with the Secretary of State on June 28, 1995. We request the following comments be considered in preparing the final regulations. Specifically, West Virginia EMS Coalition is opposed to the promulgation of rules which would restrict development of an integrated delivery system in West Virginia by eliminating the option of a risk sharing arrangement between health benefit plans and provider networks.

The West Virginia EMS Coalition supports the development of an integrated delivery system through network development, however, regulatory impediments under proposed insurance commission rules may impede the ability of providers to develop networks and assume risk under capitation of pre-payment. Our goals with respect to advocacy for appropriate regulation of provider based health plans and risk-bearing entities are:

* To ensure the ability of provider based networks to form and accept capitated and incentive based payments from health plans without themselves also being regulated as a health plan. Regulations should not require duplicative regulation of health plans and the provider entities which contract with them.

* To remove regulatory barriers for provider based entities to become or sponsor health plans themselves and to remove barriers for provider based entities entering

P.O. BOX 5374 CHARLESTON WV 25361 (304)345-2312

the market which are not grounded in public protection.

* *To advocate for health plan standards that support public accountability and the delivery of high quality coordinated care. Standards should appropriately separate health plan and provider functions.*

* *To ensure that health plan requirements applied to integrated delivery systems appropriately reflect the operating and risk differences between health plans that predominately pay claims and health plans that predominately produce health services. The two types of plans are different in the way they experience and manage risk, and the way they protect against insolvency.*

Provider networks developing in West Virginia, including the four Rural Demonstration networks, will be denied the ability to do business with purchasers of health care, including Medicaid, Medicare, and PEIA, if these regulations are adopted. These developing networks cannot be regulated in the same way that HMOs are with respect to financial solvency requirements, since these are not claims paying entities.

The West Virginia EMS Coalition encourages the Department of Insurance to help facilitate delivery system reform by removing any obstacles for the development of provider based networks and to encourage new models of health care delivery.

Sincerely,

Roger E. Bryant

Roger E. Bryant,
President

RB/ldb

P.O. BOX 5374 CHARLESTON WV 25361 (304)345-2312

ROANE GENERAL HOSPITAL

200 Hospital Drive
Spencer, WV 25276
304-927-4444
fax 304-927-5345

Copy

To: Hanley C. Clark
Insurance Commission

Attention: _____

From: Andrew Mazon, III

Date: July 28, 1995

Total pages, including cover sheet: 2

If you have any questions about this transmission, please call:

304-927-4200

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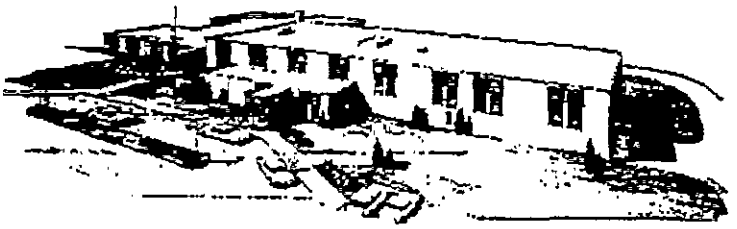
HOSPITAL
200 HOSPITAL DRIVE
SPENCER, WEST VIRGINIA 25276



TELEPHONE 927-4444 • AREA CODE 304

July 28, 1995

Mr. Hanley C. Clark
Insurance Commission
2019 Washington Street, East
P.O. Box 50540
Charleston, WV 25305-0540

Dear Mr. Clark:

I am writing to voice opposition to the promulgation of rules that would restrict provider networks, and, more especially, rural health networks from going at risk with employer groups and state payors of health insurance benefits.

I feel that states, such as Minnesota, have in existence policies that protect the public through insurance commission regulation and still afford providers that choose to network to accept risk as part of their integrated delivery systems to serve the needs of their citizens.

To mandate that provider networks meet the same criteria as insurance companies will cripple networking in our state and ultimately hurt the public that we are all committed to protect.

Please consider a policy that facilitates the development of provider-based integrated delivery systems that meet the needs of our rural communities.

Sincerely,

Andrew Mazon, III
Administrator/CEO

AM/bk

ROANE GENERAL HOSPITAL

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Spencer, WV 25276
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fax 304-927-5345

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Insurance Commission

Attention: _____

From: Andrew Mazon, III

Date: July 28, 1995

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If you have any questions about this transmission, please call:

304-927-1200

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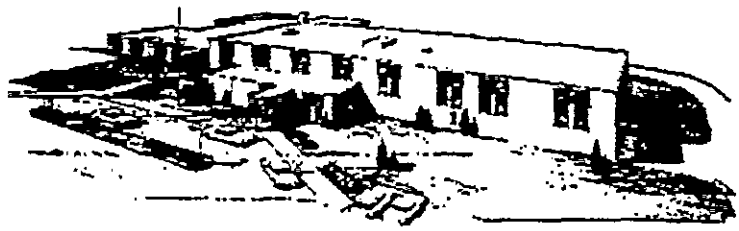

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Insurance Commission
2019 Washington Street, East
P.O. Box 50540
Charleston, WV 25305-0540

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Please consider a policy that facilitates the development of provider-based integrated delivery systems that meet the needs of our rural communities.

Sincerely,

Andrew Mazon III

Andrew Mazon, III
Administrator/CEO

AM/bk

Carelink
health plans

P.O. Box 1711
Charleston, West Virginia 25326-1711

Phone: (304) 348-2900
Fax: (304) 348-2948

July 10, 1995

RECEIVED
JUL 11 1995
LEGAL DIVISION
W. VA. INS. DEPT.

B. Keith Huffman
General Counsel
West Virginia Insurance Commission
P.O. Box 50540
2019 Washington Street, East
Charleston, WV 25305-0540

Dear Mr. Huffman:

I am writing regarding the proposed Series 43, Rules for Health Maintenance Organizations.

We hope the Department will consider the following comments as it enacts these regulations:

2.1.a. Some HMOs choose to contract on a percentage of premium basis, which is an alternative to a fixed per capita basis. These regulations should probably include that option.

3.1. If both the HMO and the health service intermediary are meeting the Department of Insurance regulations, then an opinion from an independent actuary only serves to increase costs and is unnecessary. Furthermore, an HMO and a health service intermediary may have long-range business and strategic reasons for contractual arrangements. To an independent actuary, those business goals may not be understood and there may be difficulty in getting an opinion on how financially sound the contract is. I propose that section 3.1 be amended by deleting the language after the word "commissioner".

3.1.a. I would hope that any reports between the health service intermediary and the HMO are private. To have reports become public will impede the ability of both the HMO and the health service intermediary to negotiate from a business standpoint. Simply put, if all reports and contracts are public, then the contracts are more likely to be identical. This makes pricing and contractual negotiations for both the provider organization and the HMO difficult and will decrease competition because the premiums of the HMOs will tend to be the same.

3.1.d. It is unreasonable to require a six-month reserve and a full month of funding for IBNR.

3.1.A. I would hope that adequate language regarding hold harmless would also be sufficient for this paragraph and in meeting the capital and reserve fund requirements.

3.1.f. This language would appear to negate the contract between the certificate of authority holder and the health service intermediary. Questions would arise as to whether the intermediary could simply refuse to pay a claim. If a hold harmless clause is required, then this language should be unnecessary.

3.1.h. This language should be the responsibility of the HMO. It should not be a burden placed upon a provider organization.

3.1.m. Audited financial reports prepared by an independent certified public accountant should be unnecessary. The proposed language as written could potentially require that independent physicians, pharmacies, and any other provider would have to have an independent audit. When providers are potentially contracting with several HMOs, this expense is both tremendous and unnecessary. I would hope that this requirement could be eliminated.

4.2. This language is confusing to me. It would imply that the HMO remains financially responsible for claims of providers not contracting with the intermediary. While generally this should be true, an HMO and a health services intermediary may agree in their contract that the intermediary is responsible for emergency services. Furthermore, the intermediary may be responsible for referrals for a certain esoteric services not directly available through the intermediary. This should be the option of the contracting parties to determine what services become the financial responsibility of the intermediary or the HMO.

4.7. I have great concern that by giving full access to all books and records of any health service intermediary and to any provider contracting with an intermediary that providers will be reluctant to contract if those records then become publicly available. These are private transactions between business entities and the examination should stop at the right to review the contract between the HMO and the intermediary. Furthermore, those contracts should not be publicly available because they are proprietary.

4.9. If it is possible to immediately cancel an agreement, then what happens to the members of the HMO in that situation? I would hope that some reasonable judgement would apply and there would need to be some notice to the HMO and to the intermediary so that the terms of the contracts between the HMO and the employer group can be met.

I would be happy to discuss these comments with you further and hope they are constructive.

Thank you.

Very truly yours,

Alan L. Mytty
President & CEO

ALM/ca