

**WEST VIRGINIA
SECRETARY OF STATE
NATALIE E. TENNANT
ADMINISTRATIVE LAW DIVISION**

Form #3

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JUL 27 PM 2:59
OFFICE WEST VIRGINIA
SECRETARY OF STATE

**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-5(b) and 33-2-10.

AMENDMENT TO AN EXISTING RULE: YES NO

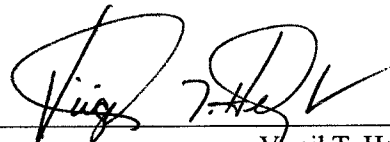
IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: 91

TITLE OF RULE BEING PROPOSED: Health Maintenance Organization Point of Service Option

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.



Virgil T. Helton
Cabinet Secretary
West Virginia Department of Revenue

Insurance Commissioner
Legislative Rule
Title 114, Series 91

HEALTH MAINTENANCE ORGANIZATION POINT OF SERVICE OPTION

TITLE 114, SERIES 91

BRIEF SUMMARY OF RULE

The rule sets forth requirements to be followed by health maintenance organizations (HMO) that offer a point of service option to its enrollees. A point of service option gives an enrollee the choice of going outside the HMO's panel of health care providers. However, the out-of-network coverage is significantly less than that of in-network coverage and may require a deductible and co-payment. The enabling legislation gave emergency rule-making authority to the Insurance Commissioner to develop standards HMOs must follow in connection with the offering of a point of service option. The rule sets such parameters and provides the Insurance Commissioner with substantial oversight in how point of service options are carried out in practice.

Department of Revenue
Agency Questionnaire

Re: Legislative Rule to be Filed

TITLE 114, SERIES 91
HEALTH MAINTENANCE ORGANIZATION POINT OF SERVICE OPTION

Question 1: Are regulations required?

No, but are expressly permitted by Senate Bill 483 (2010 RS).

Question 2: Is the rule you are proposing controversial? If yes, what are the pros and the cons?

The rule is not expected to be controversial. The rule sets forth requirements to be followed by health maintenance organizations that offer a point of service option to its enrollees.

Question 3: Is the rule you are proposing a copy of another state's rule? A model rule? Custom-drafted?

The rule is based upon an Illinois statute pertaining to the regulation of point of service options.

Question 4: What are the really important things you think the Secretary of Tax and Revenue should know about this rule and the issues that surround it?

In giving the Commissioner emergency rule-making authority to the Insurance Commissioner, the Legislature perceived a potential need to define the parameters by which a health maintenance organization may offer a point of service option to its enrollees. The rule sets such parameters and provides the Insurance Commissioner with substantial oversight in how point of service options are carried out in practice.

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period, Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: July 27, 2010

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER
ATTN: Legal Division
1124 Smith Street
Post Office Box 50540
Charleston, West Virginia 25305-0540

LEGISLATIVE RULE TITLE: HEALTH MAINTENANCE ORGANIZATION POINT
OF SERVICE OPTION
(TITLE 114, SERIES 91)

1. Authorizing statute(s) citation:

W.Va. Code §33-25A-5(b) and 33-2-10

2. a. Date filed in State Register with Notice of Hearing or Public Comment Period:

June 11, 2010.

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

N/A

c. Date of Public Hearing(s) or Public Comment Period ended:

July 12, 2010.

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

Attached X No comments received

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

July 27, 2010

Insurance Commissioner
Title 114, Series 91

- f. Name, title, address and phone/fax/e-mail numbers of agency person(s) to receive all written correspondence regarding this rule: (Please type)

Timothy R. Murphy, Associate Counsel
Insurance Commission
P.O. Box 50540
Charleston WV 25305
304-558-0401 Ext 1210
304-558-1362 FAX
Timothy.Murphy@wvinsurance.gov

- g. IF DIFFERENT FROM ITEM 'f', please give Name, title, address and phone number(s) of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)

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.

N/A

- b. Date of hearing or comment period:

N/A

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

N/A

- d. Attach findings and determinations and reasons:

N/A



SPILMAN THOMAS & BATTLE, PLLC

ATTORNEYS AT LAW

(304) 340-3829
tcox@spilmanlaw.com

July 12, 2010

Jane L. Cline, Commissioner
Att'n: Tim Murphy; Victor Mullins [via e-mail]
West Virginia Division of Insurance
1124 Smith Street
P. O. Box 50545
Charleston, West Virginia 25305

Re: Series 91

Jane
Dear Commissioner Cline:

Enclosed are Carelink's comments to Series 91, Health Maintenance Organization Point of Service. As you are aware, Carelink was primarily responsible, with the blessing of your Office, in seeking the passage of legislation to support an HMO offering POS.

Currently Carelink's sister company, Southern Health Services, Inc., offers this option in Virginia, and Carelink would like to offer a similar product in West Virginia. Carelink believes that the POS option will make its HMO product more attractive to prospective members. The major concern about POS products appears to be their financial impact on the HMO. With the promulgation of Risk Based capital requirements, the regulatory mechanism to protect the consumer and provide and ensure the financial stability of the HMO has been addressed.

However as written, the regs go well beyond what is necessary and may further cause Carelink to not offer this product in West Virginia, which would be unfortunate in a health care market in which we should be offering as many options as possible.

At your convenience, we are prepared to meet with you to discuss our concerns.

Sincerely yours,

T. Randolph Cox
T. Randolph Cox

TRC/lb;2259534
Attach.

Spilman Center . 300 Kanawha Boulevard, East | Post Office Box 273 | Charleston, West Virginia 25321-0273
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West Virginia

North Carolina

Pennsylvania

Virginia

**Carelink's Issues with Proposed POS Regulation
July 12, 2010**

Carelink was encouraged by the actions of the West Virginia Legislature when they enacted Senate Bill 483. By allowing HMOs to offer point of service coverage, the legislature created an opportunity for the citizens of West Virginia to have more choice over their health care coverage and their health care providers. As the WVOIC is aware, Carelink has been looking forward to being able to offer point of service coverage and has already submitted policy forms and rates to allow it to do so prior to the promulgation of these proposed regulations.

Carelink's sister HMOs throughout the United States have been permitted to offer, and in some states even mandated to offer, POS coverage for over 20 years with no adverse impact on their financial condition and without the burdensome requirements set forth in the proposed regulation. Since we feel our network of contracted providers have served our members and their patients well over the year, we believe most members will still choose to stay in-network for most of their health care needs. However, allowing HMOs to offer coverage with out-of-network benefits enables their members to have more choices and better accommodate their member's health care needs. It provides another option for our members and offers one more choice for consumers when they pick their health care coverage and their health care providers.

For the reasons discussed below, Carelink is discouraged that if the proposed regulation is promulgated as drafted, we will find it fiscally imprudent to offer POS coverage in West Virginia. We look forward to being able to work with the WVOIC to develop a regulation that would allow an HMO to provide West Virginia citizens more options for health insurance coverage while giving the department assurance that an HMO's financial strength would not be compromised.

§114-91-1 – no comments

§114-91-2 – Need definitions for “authorized referral services;” “non-routine services;” and “point of service services” which are undefined terms used in **§114-91-3.1.d**.

§114-91-3

3.1.d – What are “authorized referral services” and “non-routine services” and why wouldn't those obtained outside the service area be considered point of service services? We need more clarification and discussion on this provision. Would services “authorized referral services” and “non-routine services” provided by out of network providers that are located within the HMO's designated service area be considered “point of service services?”

3.1.e – Carelink questions the provision that requires an HMO to consider services contractually required to be preauthorized by the HMO and provided by an in-network provider to be treated as out-of-plan covered services. These services would simply be denied as the provider's responsibility for the provider's failure to comply with the provisions of his/her/its contract with the HMO. This is contrary to the general requirements of managed care set forth in Article 25A. The only services received out of network that are to be paid at the provider's “normal charges” are emergency health services. § 33-25A-8(7). There is no statutory authority for an HMO to pay for non-routine services or authorized referral services out of network. Therefore, these services should be treated as POS benefits.

3.2.a – Carelink would prefer to have these calculations concerning out-of-plan HMO services to be reviewed annually as opposed to quarterly. Further, are these expenditures to be reported on a paid or incurred basis? The annual review is preferable because it

Carelink's Issues with Proposed POS Regulation
July 12, 2010

evens out the payments made and does not allow the one bad quarter to affect the impact of POS payments. For example, in instances when a catastrophic payment is made in one quarter it will unnecessarily skew the percentages.

Carelink also has concerns about what the reporting form to demonstrate compliance with this requirement would look like. Carelink cannot fully comment on its concerns without reviewing a copy of the proposed reporting form it would be required to complete.

3.2.b – If the requirement in **3.2.a** is changed to restrict an HMO that offers POS benefits from expending more than 20% of its total expenditures for all its members for out-of-plan covered services per calendar year instead of quarter, this requirement should also be changed to say that an HMO cannot exceed this threshold in **3.1.a** by more than 2% per calendar year and it must effect compliance by the end of the following year.

3.2.c – This subsection should also be revised to state that if the HMO does not demonstrate compliance with **3.1.a** in the next annual report, not quarterly report, than it will not be able to offer POS coverage to any new or renewing group until compliance is demonstrated or allowed by the Commissioner.

3.3.a – Carelink already files electronic quarterly financial statements with the NAIC which are accessible by the WVOIC; however, we recommend, based on our recommendations for **3.2.a-c**, that any specific reporting requirements for HMOs offering POS coverage would be annually.

3.3.b – d – Carelink would need to review specific reporting forms prepared by the WVOIC in order to comment on the provisions in these subsections of the proposed regulation.

3.3.e – Carelink wonders if the intent of this subsection is to require an HMO that offers POS coverage to make additional deposit that is the **greater of 125%** of HMO's annual projected POS claims **or \$200,000**? By way of example, assume that Carelink has 3,000 POS members who were projected to incur \$300 in monthly medical expenses. Based on the language in the proposed regulation, Carelink would be expected to make an additional deposit of \$13.5 million. Carelink questions whether this was the intent of the proposed regulation. Carelink would find this requirement unduly burdensome and it may well preclude Carelink from being able to offer such a product in West Virginia.

3.3.g – Carelink currently has stop-loss coverage for its HMO business which would apply to its POS business as well. Therefore, Carelink is not opposed to a requirement for an HMO doing POS business to maintain stop loss (reinsurance) coverage but not at the levels set forth in the proposed regulation which far exceed the coverage we have today. The increase in premiums for stop loss coverage associated with lowering the deductible and coinsurance levels may also preclude us from being able to offer POS coverage in West Virginia.

3.3.e – g – West Virginia has adopted the NAIC risk-based capital model laws. Carelink believes, and obviously the NAIC believed, that this Act provides sufficient protection for West Virginia citizens to ensure that the WVOIC has ample opportunity to take action against an HMO if it does not maintain its risk-based capital at the prescribed levels. Based on our most recent annual statement, Carelink's risk-based capital is at \$33.7 million which far exceed its Authorized Control Level of \$5.9 million. Since the risk-based capital calculations account for the indemnification of health care costs for out-of-network claims, claims reserves, and the level of stop loss coverage an HMO has, Carelink does not feel

**Carelink's Issues with Proposed POS Regulation
July 12, 2010**

that it is necessary to impose additional restrictions on HMOs that offer POS coverage for additional deposits, claims reserves, or stop loss coverage.

3.4 – Carelink feels that requiring an HMO to submit and have approved by the WVOIC a compliance plan prior to being able to offer POS coverage in West Virginia is unnecessary. Benefit design information is already submitted to and must be approved by the WVOIC as all policy forms must be filed and approved by the WVOIC prior to use. In addition, quarterly financial statements are already available to the WVOIC which demonstrate the HMO's financial position and risk-based capital reporting is part of the annual financial statement filings which are already available to the WVOIC as well. However, if the WVOIC still feels that a compliance plan must be submitted in addition to the information currently required to be filed with the department, Carelink would suggest that there be time frames established in the regulation for the HMO to file the plan and for the WVOIC to take action on the plan.

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ATTACHEMENT TO QUESTION 2(d):

Multiple comments were received from Carelink regarding the proposed rule §114-91. Below you will find the written responses of the Insurance Commissioner to the public comments received in regard to the newly proposed rule, which was filed with the West Virginia Secretary of State for public comment on June 11, 2010. The comments received were thoroughly reviewed, considered and addressed herein.

General Comments

Carelink begins by asserting their encouragement with the enactment of SB483 (RS 2010). It states that by allowing a health maintenance organization (“HMO”) to offer point of service (“POS”) coverage, the Legislature created an opportunity for West Virginia citizens to have more choice over their health care coverage and health care providers. Carelink points out that its sister HMOs throughout the United States have been permitted and often mandated to offer POS coverage for over twenty years with no adverse impact on their financial condition and without the burdensome requirements set forth in the newly proposed rule. It further asserts that if the proposed rule is promulgated as drafted, that it would find it fiscally imprudent to offer POS coverage in West Virginia. Carelink hopes that a rule could be developed to allow an HMO to provide West Virginia citizens more options for health insurance coverage while giving the Insurance Commissioner assurance that a HMO’s financial strength would not be compromised.

The Commissioner acknowledges these general comments and agrees that some of the rule provisions should be modified.

§114-91-2. Definitions

Carelink suggests including definitions for “authorized referral services,” “non-routine services” and “point of service services,” which are referenced in subdivision 3.1.d.

The Commissioner responds that the intent of subdivision 3.1.d was to identify areas of medical services that a HMO may not consider to be out-of-plan services subject to the point of service option. The Commissioner agrees that the provision poorly conveys the intent and accordingly amends it to better clarify the exempted services. In doing so, the terms “authorized referral services,” “non-routine services” and “point of service services” have been removed.

§114-91.3. Requirements for Point of Service Option

Regarding subdivision 3.1.d, Carelink questions what "authorized referral services" and "non-routine services" are and why those that are obtained outside the service area be considered point of service services. They assert that they need more clarification on this provision. They also question if "authorized referral services" and "non-routine services" provided by out of network providers that are located within the HMO's designated service area be considered "point of service services."

In reply, the Commissioner reasserts her response to Carelink's comments concerning the Definitions section above.

Concerning subdivision 3.1.e, Carelink questions the provision that requires a HMO to consider services contractually required to be preauthorized by the HMO and provided by an in-network provider to be treated as out-of-plan covered services. It states that these services would simply be denied as the provider's responsibility for the provider's failure to comply with the provisions of his/her/its contract with the HMO. Carelink also asserts that this is contrary to the general requirements of managed care set forth in Article 25A of the Insurance Code and that the only services received out of network that are to be paid at the provider's "normal charges" are emergency health services. It states that there is no statutory authority for an HMO to pay for non-routine services or authorized referral services out of network. Therefore, they feel that these services should be treated as POS benefits.

The Commissioner notes that the subject provision gives the HMO discretion to treat the services at issue as in-plan covered services. It does not require the HMO to do so. Because this provision may result in confusion and because the HMO may treat the subject services as in-plan covered services without the provision in place, the Commissioner believes it should be removed and has accordingly done so.

For subdivision 3.2.a, Carelink states that they prefer to have the calculations concerning out-of-plan HMO services to be reviewed annually as opposed to quarterly. Carelink avers that the annual review is preferable because it evens out the payments made and does not allow the one bad quarter to affect the impact of POS payments. It also questions what the reporting form to demonstrate compliance with this requirement will look like.

The Commissioner agrees that an annual report is more reasonable under the circumstances. In response to the inquiry about the reporting form, the Commissioner states that she will prepare the form once the rule is promulgated. To do so before would be premature.

Concerning subdivision 3.2.b, Carelink makes note that if the change in subdivision 3.2.a is made to restrict an HMO that offers POS benefits from expending more than twenty percent of its total expenditures for all its members for out-of-plan covered services per calendar year rather than quarterly, then the requirement found in

subdivision 3.2.b should also be changed to say that an HMO cannot exceed this threshold in subdivision 3.1.a by more than 2% per calendar year and it must effect compliance by the end of the following year.

The Commissioner agrees and has made the change.

Similarly, Carelink notes that if the requirement in subdivision 3.2.a is changed then subdivision 3.2.c should also be revised to state that if the HMO does not demonstrate compliance with subdivision 3.1.a in the next annual report, not quarterly report, then it will not be able to offer POS coverage to any new or renewing group until compliance is demonstrated or allowed by the Commissioner.

The Commissioner agrees and has made the change.

Regarding subdivision 3.3.a, Carelink explains that it already files electronic quarterly financial statements with the NAIC which is accessible by the OIC; however, it was recommended, based on its recommendations for subdivisions 3.2.a-c, that any specific reporting requirements for HMOs offering POS coverage should be annually.

The Commissioner responds by noting that the financial statement required by subdivision 3.3.a is not intended to be the same as the quarterly financial statement filed with the National Association of Insurance Commissioners. The Commissioner agrees that since subdivisions 3.2.a-c were changed to reflect an annual time frame, the reporting requirement set forth in subdivision 3.3.a should also be on an annual basis. This change has accordingly been made.

Carelink explains that for sections 3.3.b-d that they would need to review specific reporting forms prepared by the OIC in order to comment on the provisions in these subsections of the proposed rule.

The Commissioner responds that the reporting form will be devised so a HMO provides adequate data concerning the point of service option so as to satisfy the Commissioner that the HMO has the fiscal, administrative and marketing capacity to manage such an option.

For subdivision 3.3.e, Carelink questions if the intent of this subsection is to require an HMO that offers POS coverage to make additional deposit that is greater of 125% of the HMO's annual projected POS claims or \$200,000. They give example that if Carelink has 3,000 POS members who were projected to incur \$300 in monthly medical expenses, then based on the proposed rule, Carelink would be expected to make an additional deposit of 13.5 million. They question if this was the intent of the proposed rule. They assert that they would find this requirement unduly burdensome and it may preclude Carelink from being able to offer such a product in West Virginia.

The Commissioner responds that the intent of this provision is to ensure that a HMO is fiscally capable to cover claims. After a review W. Va. Code §33-40-1 *et seq.*

(Risk-Based Capital for Insurers), the Commissioner believes that subdivision 3.3.e is unnecessary considering that the provisions of Article 40 are sufficient to ensure the solvency of HMOs. The Commissioner has accordingly removed that subdivision.

Concerning subdivision 3.3.g, Carelink explains that it currently has stop-loss coverage for its HMO business which would apply to its POS business as well. Therefore, they are not opposed to a requirement for an HMO doing POS business to maintain stop-loss (reinsurance) coverage but not at the levels set forth in the proposed rule which far exceed the coverage they currently have. They state that the increase in premiums for stop loss coverage associated with lowering the deductible and coinsurance levels may also preclude them from being able to offer POS coverage in West Virginia.

The Commissioner agrees to modify this provision but only to the extent that she retains discretion to set the deductible levels of the reinsurance or stop-loss coverage depending on the financial situation of the HMO.

In regards to 3.3.e-g, Carelink notes that West Virginia has adopted the NAIC risk-based capital model law, codified at W. Va. Code §33-40-1 *et seq.* Carelink believes that this Article 40 provides sufficient protection for West Virginia citizens to ensure that the Commissioner has ample opportunity to take action against an HMO if it does not maintain its risk-based capital at the prescribed levels. Carelink further states that based on its most recent annual statement, that its risk-based capital is at \$33.7 million, which far exceeds its authorized control level of \$5.9 million. It asserts that since the risk-based capital calculations account for the indemnification of health care costs for out-of-network claims, claim reserves and the level of stop loss coverage an HMO has, they do not feel that it is necessary to impose additional restrictions on an HMO that offers POS coverage for additional deposits, claims reserves or stop loss coverage.

The Commissioner responds by noting that, as mentioned above in response to other comments, she has removed the deposit requirement set forth in subdivision 3.3.e and has modified the reinsurance requirement of subdivision 3.3.g. The Commissioner believes that the reserve requirement in subdivision 3.3.f is a reasonable and necessary protection for HMO members. Therefore, subdivision 3.3.f is retained as initially proposed.

Lastly, for subsection 3.4, Carelink believes that requiring a HMO to submit and have approved by the Commissioner a compliance plan prior to being able to offer POS coverage in West Virginia is unnecessary. Carelink states that benefit design information is already submitted to and must be approved by the Commissioner as all policy forms must be filed and approved by the Commissioner prior to use. It also states that quarterly financial statements are already available to the Commissioner that demonstrate the HMO's financial position. Carelink asserts that if the Commissioner still feels that a compliance plan must be submitted in addition to the information currently required to be filed with her, that it suggests that there be time frames established in the rule for the HMO to file the plan and for the OIC to take action on the plan.

The Commissioner believes that subsection 3.4 is a proper means to ensure HMO compliance with the rule. The Commissioner also responds by stating that it will add a new subsection, 3.5, to state that the compliance plan will be automatically approved if the Commissioner does not disapprove of the plan within thirty days after its receipt.

Insurance Commissioner
Legislative Rule
Title 114, Series 91

HEALTH MAINTENANCE ORGANIZATION POINT OF SERVICE OPTION

TITLE 114, SERIES 91

STATEMENT OF CIRCUMSTANCES

The bill permitting the promulgation of rules to address health maintenance organizations offering a point of service option to its enrollees was enacted in 2010 (SB 483) and is effective June 11, 2010.

With the passage of Senate Bill 483, W.Va. Code §33-25A-5(b) provides the following:

"The commissioner shall propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code limiting or regulating the powers of health maintenance organizations which the commissioner finds to be in the public interest. The commissioner may promulgate emergency rules pursuant to the provisions of section fifteen, article three, chapter twenty-nine-a of this code to implement standards and requirements for a point of service option."

The proposed rule sets forth standards and requirements for a point of service option.

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Health Maintenance Organization Point of Service Option (Title 114, Series 91)

Type of Rule: Legislative Interpretive Procedural

Agency: WV Offices of the Insurance Commissioner

Address: Post Office Box 50540
1124 Smith Street, Greenbrooke Building
Charleston, West Virginia 25305-0540

Phone Number: (304) 558-0401 Email: Victor.Mullins@wvinsurance.gov

Fiscal Note Summary

Summarize in a clear and concise manner what impact this measure will have on costs and revenues of state government.

The rule will have no additional fiscal impact upon state government.

Fiscal Note Detail

Show over-all effect in Item 1 and 2 and, in Item 3, give an explanation of Breakdown by fiscal year, including long-range effect.

FISCAL YEAR			
Effect of Proposal	Current Increase/Decrease (use "-")	Next Increase/Decrease (use "-")	Fiscal Year (Upon Full Implementation)
1. Estimated Total Cost	N/A	N/A	N/A
Personal Services	N/A	N/A	N/A
Current Expenses	N/A	N/A	N/A
Repairs & Alterations	N/A	N/A	N/A
Assets	N/A	N/A	N/A
Equipment	N/A	N/A	N/A
Other	N/A	N/A	N/A
2. Estimated Total Revenues	N/A	N/A	N/A

Rule Title: Health Maintenance Organization Point of Service Option (Title 114, Series 91)

3. **Explanation of above estimates (including long-range effect):**
Please include any increase or decrease in fees in your estimated total revenues.

N/A

MEMORANDUM

Please identify any areas of vagueness, technical defects, reasons the proposed rule **would not** have a fiscal impact, and/or any special issues **not** captured elsewhere on this form.

--

Date: _____

Signature of Agency Head or Authorized Representative

Victor A. Mullins, Associate Counsel

**TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER**

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

Section.

- 114-91-1. General
- 114-91-2. Definitions.
- 114-91-3. Requirements for Point of Service Option.

**TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER**

FILED
JUL 27 PM 2:59

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

OFFICE WEST VIRGINIA
SECRETARY OF STATE

§114-91-1. General.

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

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

1.3. Filing Date. --

1.4. Effective Date. --

§114-91-2. Definitions.

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

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

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

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

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

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

**Insurance Commissioner
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Title 114, Series 91**

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

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

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

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

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

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

3.1.d. May not consider the following services as out-of-plan covered services subject to the point of service option:

3.1.d.1. Emergency medical services as defined by W.Va. Code §33-25A-8d(b)(5)(A); and

3.1.d.2. Any service performed by an out-of-network provider that has been preapproved or preauthorized by the health maintenance organization due to not having a panel provider available or capable to perform the service; and

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

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

**Insurance Commissioner
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AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.”

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

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

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

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

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

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

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

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

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

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

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

3.3.f. Maintain and file with the Commissioner, reinsurance or stop-loss coverage protecting against catastrophic losses concerning out-of-plan covered services. The reinsurance or stop-loss coverage must have deductible levels acceptable to the Commissioner and be placed with licensed authorized reinsurers qualified to do business in West Virginia.

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

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

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

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

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

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

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

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3.5. If the Commissioner does not disapprove of the compliance plan required by subsection 3.4 of this rule within the initial thirty-day period after receipt, the compliance plan shall be deemed approved.