

FILED

2001 MAY -2 P 4: 28

OFFICE WEST VIRGINIA
SECRETARY OF STATE

WEST VIRGINIA LEGISLATURE

FIRST REGULAR SESSION, 2001



ENROLLED

House Bill No. 2389

(By Delegates Leach, Hatfield, Smirl and Fleischauer)



Passed April 14, 2001

In Effect Ninety Days from Passage

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H. B. 2389

(BY DELEGATES LEACH, HATFIELD, SMIRL AND FLEISCHAUER)

[Passed April 14, 2001; in effect ninety days from passage.]

AN ACT to amend and reenact section two, article twenty-five-a, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, relating to health maintenance organizations (HMOs); definitions; and providing that certain advanced nurse practitioners may serve in lieu of an HMO subscriber's primary care physician.

Be it enacted by the Legislature of West Virginia:

That section two, article twenty-five-a, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted to read as follows:

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-2. Definitions.

- 1 (1) "Basic health care services" means physician, hospital,
- 2 out-of-area, podiatric, chiropractic, laboratory, X ray, emer-
- 3 gency, short-term mental health services not exceeding twenty
- 4 outpatient visits in any twelve-month period, and cost-effective

5 preventive services including immunizations, well-child care,
6 periodic health evaluations for adults, voluntary family plan-
7 ning services, infertility services and children's eye and ear
8 examinations conducted to determine the need for vision and
9 hearing corrections, which services need not necessarily include
10 all procedures or services offered by a service provider.

11 (2) "Capitation" means the fixed amount paid by a health
12 maintenance organization to a health care provider under
13 contract with the health maintenance organization in exchange
14 for the rendering of health care services.

15 (3) "Commissioner" means the commissioner of insurance.

16 (4) "Consumer" means any person who is not a provider of
17 care or an employee, officer, director or stockholder of any
18 provider of care.

19 (5) "Copayment" means a specific dollar amount, or
20 percentage, except as otherwise provided for by statute, that the
21 subscriber must pay upon receipt of covered health care
22 services and which is set at an amount or percentage consistent
23 with allowing subscriber access to health care services.

24 (6) "Employee" means a person in some official employ-
25 ment or position working for a salary or wage continuously for
26 no less than one calendar quarter and who is in such a relation
27 to another person that the latter may control the work of the
28 former and direct the manner in which the work shall be done.

29 (7) "Employer" means any individual, corporation, partner-
30 ship, other private association, or state or local government that
31 employs the equivalent of at least two full-time employees
32 during any four consecutive calendar quarters.

33 (8) "Enrollee", "subscriber" or "member" means an
34 individual who has been voluntarily enrolled in a health

35 maintenance organization, including individuals on whose
36 behalf a contractual arrangement has been entered into with a
37 health maintenance organization to receive health care services.

38 (9) "Evidence of coverage" means any certificate, agree-
39 ment or contract issued to an enrollee setting out the coverage
40 and other rights to which the enrollee is entitled.

41 (10) "Health care services" means any services or goods
42 included in the furnishing to any individual of medical, mental
43 or dental care, or hospitalization or incident to the furnishing of
44 the care or hospitalization, osteopathic services, chiropractic
45 services, podiatric services, home health, health education, or
46 rehabilitation, as well as the furnishing to any person of any and
47 all other services or goods for the purpose of preventing,
48 alleviating, curing or healing human illness or injury.

49 (11) "Health maintenance organization" or "HMO" means
50 a public or private organization which provides, or otherwise
51 makes available to enrollees, health care services, including at
52 a minimum basic health care services and which:

53 (a) Receives premiums for the provision of basic health
54 care services to enrollees on a prepaid per capita or prepaid
55 aggregate fixed sum basis, excluding copayments;

56 (b) Provides physicians' services primarily: (i) Directly
57 through physicians who are either employees or partners of the
58 organization; or (ii) through arrangements with individual
59 physicians or one or more groups of physicians organized on a
60 group practice or individual practice arrangement; or (iii)
61 through some combination of paragraphs (i) and (ii) of this
62 subdivision;

63 (c) Assures the availability, accessibility and quality,
64 including effective utilization, of the health care services which

65 it provides or makes available through clearly identifiable focal
66 points of legal and administrative responsibility; and

67 (d) Offers services through an organized delivery system in
68 which a primary care physician or primary care provider is
69 designated for each subscriber upon enrollment. The primary
70 care physician or primary care provider is responsible for
71 coordinating the health care of the subscriber and is responsible
72 for referring the subscriber to other providers when necessary:
73 *Provided*, That when dental care is provided by the health
74 maintenance organization the dentist selected by the subscriber
75 from the list provided by the health maintenance organization
76 shall coordinate the covered dental care of the subscriber, as
77 approved by the primary care physician or the health mainte-
78 nance organization.

79 (12) "Impaired" means a financial situation in which, based
80 upon the financial information which would be required by this
81 chapter for the preparation of the health maintenance organiza-
82 tion's annual statement, the assets of the health maintenance
83 organization are less than the sum of all of its liabilities and
84 required reserves including any minimum capital and surplus
85 required of the health maintenance organization by this chapter
86 so as to maintain its authority to transact the kinds of business
87 or insurance it is authorized to transact.

88 (13) "Individual practice arrangement" means any agree-
89 ment or arrangement to provide medical services on behalf of
90 a health maintenance organization among or between physi-
91 cians or between a health maintenance organization and
92 individual physicians or groups of physicians, where the
93 physicians are not employees or partners of the health mainte-
94 nance organization and are not members of or affiliated with a
95 medical group.

96 (14) "Insolvent" or "insolvency" means a financial situation
97 in which, based upon the financial information that would be
98 required by this chapter for the preparation of the health

99 maintenance organization's annual statement, the assets of the
100 health maintenance organization are less than the sum of all of
101 its liabilities and required reserves.

102 (15) "Medical group" or "group practice" means a profes-
103 sional corporation, partnership, association or other organiza-
104 tion composed solely of health professionals licensed to
105 practice medicine or osteopathy and of other licensed health
106 professionals, including podiatrists, dentists and optometrists,
107 as are necessary for the provision of health services for which
108 the group is responsible: (a) A majority of the members of
109 which are licensed to practice medicine or osteopathy; (b) who
110 as their principal professional activity engage in the coordinated
111 practice of their profession; (c) who pool their income for
112 practice as members of the group and distribute it among
113 themselves according to a prearranged salary, drawing account
114 or other plan; and (d) who share medical and other records and
115 substantial portions of major equipment and professional,
116 technical and administrative staff.

117 (16) "Premium" means a prepaid per capita or prepaid
118 aggregate fixed sum unrelated to the actual or potential utiliza-
119 tion of services of any particular person which is charged by the
120 health maintenance organization for health services provided to
121 an enrollee.

122 (17) "Primary care physician" means the general practitio-
123 ner, family practitioner, obstetrician/gynecologist, pediatrician
124 or specialist in general internal medicine who is chosen or
125 designated for each subscriber who will be responsible for
126 coordinating the health care of the subscriber, including
127 necessary referrals to other providers.

128 (18) "Primary care provider" means a person who may be
129 chosen or designated in lieu of a primary care physician for
130 each subscriber, who will be responsible for coordinating the

131 health care of the subscriber, including necessary referrals to
132 other providers, and includes:

133 (a) An advanced nurse practitioner practicing in compliance
134 with article seven, chapter thirty of this code and other applica-
135 ble state and federal laws, who develops a mutually agreed
136 upon association in writing with a primary care physician on the
137 panel of and credentialed by the health maintenance organiza-
138 tion; and

139 (b) A certified nurse-midwife, but only if chosen or
140 designated in lieu of a subscriber's primary care physician or
141 other primary care provider during the subscriber's pregnancy
142 and for a period extending through the end of the month in
143 which the sixty-day period following termination of pregnancy
144 ends.

145 (c) Nothing in this subsection may be construed to expand
146 the scope of practice for advanced nurse practitioners as
147 governed by article seven, chapter thirty of this code or any
148 legislative rule, or for certified nurse-midwives, as defined in
149 article fifteen, chapter thirty of this code.

150 (19) "Provider" means any physician, hospital or other
151 person or organization which is licensed or otherwise autho-
152 rized in this state to furnish health care services.

153 (20) "Uncovered expenses" means the cost of health care
154 services that are covered by a health maintenance organization,
155 for which a subscriber would also be liable in the event of the
156 insolvency of the organization.

157 (21) "Service area" means the county or counties approved
158 by the commissioner within which the health maintenance
159 organization may provide or arrange for health care services to
160 be available to its subscribers.

161 (22) "Statutory surplus" means the minimum amount of
162 unencumbered surplus which a corporation must maintain
163 pursuant to the requirements of this article.

164 (23) "Surplus" means the amount by which a corporation's
165 assets exceeds its liabilities and required reserves based upon
166 the financial information which would be required by this
167 chapter for the preparation of the corporation's annual state-
168 ment except that assets pledged to secure debts not reflected on
169 the books of the health maintenance organization shall not be
170 included in surplus.

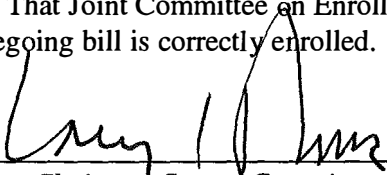
171 (24) "Surplus notes" means debt which has been subordi-
172 nated to all claims of subscribers and general creditors of the
173 organization.

174 (25) "Qualified independent actuary" means an actuary who
175 is a member of the American academy of actuaries or the
176 society of actuaries and has experience in establishing rates for
177 health maintenance organizations and who has no financial or
178 employment interest in the health maintenance organization.


179 (26) "Quality assurance" means an ongoing program
180 designed to objectively and systematically monitor and evaluate
181 the quality and appropriateness of the enrollee's care, pursue
182 opportunities to improve the enrollee's care and to resolve
183 identified problems at the prevailing professional standard of
184 care.

185 (27) "Utilization management" means a system for the
186 evaluation of the necessity, appropriateness and efficiency of
187 the use of health care services, procedures and facilities.

That Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.



Chairman Senate Committee



Chairman House Committee

Originating in the House.

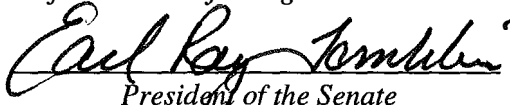
In effect ninety days from passage.



Clerk of the Senate



Clerk of the House of Delegates

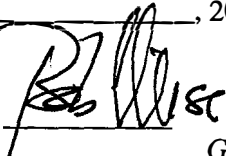


President of the Senate



Speaker of the House of Delegates

The within is approved this the 30th
day of April, 2001.



Governor

PRESENTED TO THE

GOVERNOR

Date 4/20/01

Time 5:16 pm