COMMONWEALTH OF VIRGINIA

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STATE CORPORATION COMMISSION

BUREAU OF INSURANCE

October 7, 1987

Administrative Letter 1987-15

TO: ALL HEALTH MAINTENANCE ORGANIZATIONS

RE: INSURANCE REGULATION 28

On September 1, 1987, Insurance Regulation 28, entitled "Rules Governing Health Maintenance Organizations", became effective. Immediate attention must be given to the form filings required by Subsection 7(A)(3) of this regulation and the filing of provider contracts addressed by Subsection 12(C).

Subsection 7(A)(3) requires that each health maintenance organization (HMO) licensed in Virginia report quarterly all uncovered expenses for the previous three months. Attached is a reproducible form, Supplementary Statement, Covered and Uncovered Expenses, which every licensed HMO must complete and file for the three month periods ending on December 31, March 31, and June 30 and September 30 on or before March 1, May 15, August 15 and November 15 respectively of each year. Proper completion and timely submission of this form is critical to the monitoring of an HMO's compliance with net worth requirements set forth in Subsection 7(A) of Regulation 28. In filling out the Supplementary Statement, please note the following guidelines:

1. Subsection 7(H) is very explicit in defining what constitutes a "covered" expense and the instructions on the Supplementary Statement reflect this. Unless an incurred expense fits into one of the specifically designated "covered" categories, it shall not be reported as covered unless prior written approval is obtained from the State Corporation Commission through the Bureau of Insurance. Any HMO shall not presume to report expenses as covered because of security deposits, surety bonds, insolvency insurance, affiliate guarantees or other mechanisms outside of the definition of covered expense given by Subsection 7(H).

2. Subsection 7(H)(1) prescribes very specific "hold harmless" language for all provider contracts after September 1, 1987, if an HMO wishes to report expenses incurred under those contracts as covered. Expenses incurred under provider contracts without the precise language of Subsection 7(H)(1) [Subsection 7(H)(2) for subcontracting providers] must be reported as uncovered. For provider contracts in effect prior to September 1, 1987, Subsection 7(H)(3) does allow expenses within the scope of "substantially similar hold harmless agreements" to be reported as covered until September 1, 1988.

3. The Supplementary Statement relates to all expenses incurred by the total HMO entity, not just expenses incurred or allocated to Virginia service areas. For multijurisdictional HMOs, medical expenses incurred under provider contracts without the hold harmless language prescribed by Subsection 7(H) must be reported as uncovered.

4. In the Supplementary Statement, expenses are reported for a previous three month period only. This is unlike Virginia's requirements for Report #2, Statement of Revenue and Expenses, in an HMO's Annual and Quarterly Statement blanks, where revenue and expenses are cumulative and year-to-date.

5. HMOs should follow Subsection 7(H) as a guideline for breaking out covered versus uncovered liabilities in completing Report #1 - Part B: Balance Sheet Liability and Net Worth of their Annual and Quarterly Statements.

All HMOs licensed in Virginia must begin filing of the Supplementary Statement with their submission of the Quarterly Statement for the third quarter due on November 15, 1987.

Subsection 12(C) of Regulation 28 addresses the statutory filing requirements of Virginia Code Section 38.2-4311, pursuant to which contracts to provide health care services must be filed fifteen days before use. Each individual contract need not be filed provided that certain conditions are met:

1. Individual contracts must contain the same precise language as contained in the standard contract used by the HMO and filed with the Commission.

2. The HMO has filed with the Commission a current list of the names and locations of the providers who have signed the standard contract.

   Any HMO using this "list system" shall file an updated list on March 1, May 15, August 15 and November 15 of each year. The initial provider list and all subsequent updates should be formatted so as to clearly relate each individual provider to a particular standard contract on file. Each filed contract must be identified by a form number in the lower left-hand corner of the contract form.

3. The HMO itself must maintain its own complete file of all individual contracts made with health care providers. This file shall be subject to examination.

An HMO is required to file with the Commission only those contracts relating to delivery systems serving Virginia residents. Multijurisdictional HMOs must file contracts with non-Virginia providers if such providers are part of a delivery system rendering "in-area" health care services to Virginia enrollees. For example, an HMO in the Washington, D.C. metropolitan area would generally file contracts with Virginia, Maryland, and D.C. providers

Multistate HMOs filing financial reports with covered medical expenses incurred in jurisdictions not contiguous to Virginia must be able to substantiate these by providing the appropriate provider contracts during any examination by the Commission.

The filing requirements of Subsection 12(C) include subcontracts between entities which have contracted directly with the HMO and health care providers rendering services to enrollees, i.e. between an IPA-like entity and health care professionals. Attention is again directed to Subsection 7(H)(2) regarding the treatment of covered expenses incurred within the scope of subcontracts.

All provider contracts submitted should be clearly identified with a contract form number in the lower left-hand corner of the front page.

All filings and inquiries should be directed to:

Company Licensing Section
Bureau of Insurance
State Corporation Commission of Virginia
P. O. Box 1157
Richmond, VA 23209

Sincerely yours,

Steven T. Foster
Commissioner of Insurance

SUPPLEMENTARY STATEMENT
COVERED AND UNCOVERED EXPENSES
FOR THE QUARTER ENDING_____
OF THE_____
(NAME)

EXPENSES	COVERED	UNCOVERED	TOTAL
MEDICAL AND HOSPITAL			
(1) PHYSICIAN SERVICES	.....	.....	.....
(2) OTHER PROFESSIONAL SERVICES	.....	.....	.....
(3) OUTSIDE REFERRALS	.....	.....	.....
(4) EMERGENCY ROOM	.....	.....	.....
(5) OUT OF AREA-OTHER	.....	.....	.....
(6) OCCUPANCY	.....	.....	.....
(7) DEPRECIATION AND AMORTIZATION	.....	.....	.....
(8) INPATIENT	.....	.....	.....
(9) INSURANCE	.....	.....	.....
(10) OTHER MEDICAL	.....	.....	.....
(11) INCENTIVE POOL ADJUSTMENT	.....	.....	.....
(12) TOTAL MEDICAL AND HOSPITAL (ITEMS 1-11)			
ADMINISTRATION			
(13) COMPENSATION	.....	.....	.....
(14) INTEREST EXPENSE	.....	.....	.....
(15) OCCUPANCY	.....	.....	.....
(16) DEPRECIATION AND AMORTIZATION	.....	.....	.....
(17) MARKETING	.....	.....	.....
(18) OTHER	.....	.....	.....
(19) TOTAL ADMINISTRATION (ITEMS 13-19)			
(20) TOTAL EXPENSES INCURRED (ITEMS 12+19)			
RECONCILIATION			
(21) GENERAL EXPENSES UNPAID AT END OF PREVIOUS QUARTER	.....	.....	.....
(22) GENERAL EXPENSES UNPAID AT END OF CURRENT QUARTER	.....	.....	.....
(23) GENERAL EXPENSES PAID DURING CURRENT QUARTER (ITEMS 20+21-22)			

* SEE INSTRUCTIONS ON BACK

SCCBOIHMO-11

INSTRUCTIONS

Supplementary Statement of Covered and Uncovered Expenses to be Submitted to the Virginia State Corporation Commission, Bureau of Insurance

The information contained in this statement must be reported on a noncumulative, quarterly basis as opposed t the Quarterly and Annual Financial Reports ("Orange Blanks"), which are reported cumulatively.

Please note: This report should represent a breakdown of the HMO's total expenses, not just expens allocated to Virginia business.

Covered expenses are 1) any expenses of an HMO which is owed or paid to a health care provider under contra if the contract has previously been submitted to the Bureau of Insurance and contains acceptable langua holding enrollees harmless ("hold harmless language"), 2) any interest expense relating to repayment of a fully subordinated debt, 3) a non-cash expense - i.e. - depreciation, and 4) any other expense which has h prior approval by the Commission to be reported as covered.

Any expense which is not covered is considered uncovered.