BUREAU OF INSURANCE

November 10, 1998

ADMINISTRATIVE LETTER 1998-11

TO: Health Maintenance Organizations Licensed in Virginia

RE: Service Area Concerns and Notices of Material Transactions

In recent months, the Bureau of Insurance (Bureau) has received a number of questions concerning the "MCHIP" legislation contained in Senate Bill 712 of the 1998 General Assembly and how it will impact the regulation of HMOs. Many questions concern the regulatory recognition of service areas and changes in service areas. This letter answers some of these questions by identifying pertinent statutes in Title 38.2 of the Code of Virginia and some related procedures. These procedures take into account statutes in Chapters 43 (§ 38.2-4300 et seq.) and 58 (§ 38.2-5800 et seq.) of Title 38.2.

BACKGROUND

Senate Bill 712 defined and introduced the concept of "managed care health insurance plans" or "MCHIPs." In the process, it amended multiple provisions in Chapter 43 authorizing regulation of health maintenance organizations (HMOs) and, in addition, added a new Chapter 58 (§ 38.2-5800 et seq.) in Title 38.2 and new articles in Title 32.1 at §§ 32.1-137.1 et seq. and 32.1-137.7 et seq. All of the new provisions affect HMOs because, by definition of the term "MCHIP," an HMO is deemed to be offering one or more MCHIPs. The Virginia Department of Health (VDH) is responsible for provisions in Title 32.1 of the Code of Virginia. The State Corporation Commission shall apply the provisions in Title 38.2 of the Code of Virginia.

STATUTORY PROVISIONS

"Service area" is now defined in the Code of Virginia for all HMOs and other health carriers managing care through the operation of one or more MCHIPs. Section 38.2-5800 defines service area as follows:

> "Service area" means a clearly defined geographic area in which a health carrier has directly or indirectly arranged for the provision of health care services to be generally available and readily accessible to covered persons of an MCHIP.

This statutory definition supplants and supercedes the service area definition in 14 VAC 5-210-40. The definition is applicable for any health carrier that defines, describes, offers or delivers health care services, by reference to a geographic area. We believe the definition in § 38.2-5800 is compatible with the "service area" definition in § 38.2-3431 relating to health plans that are offered to employees of small employers.

Section 38.2-5803 requires HMOs and other health carriers operating an MCHIP in Virginia on or after July 1, 1998, to give an MCHIP's covered person a description of the service area or areas within which the MCHIP shall provide health care services. The service area description is to be provided at the time of enrollment or at the time the contract or evidence of coverage is issued. In addition, a description of the service area or areas is to be made available to covered persons upon request or at least annually. Additionally, HMOs are to disclose service areas or counties on the jurat page of the annual and quarterly statements filed pursuant to § 38.2-4307. The Commission requires that these disclosures describe service area by reference to city and county. The statutory requirements in Chapter 58 impose on HMOs and other health carriers disclosure requirements which have been applied to HMOs since 1987 pursuant to 14 VAC 5-210-100 B 8. On and after July 1, 1998, market conduct examinations may consider whether compliance is evidenced in the records of the health carrier. HMOs and other health carriers are expected to keep the service area descriptions current and available upon request to regulators as well as covered persons.

Senate Bill 712 removed from § 38.2-4301 statutory provisions which required, as conditions of licensure, that HMOs file descriptions of geographic service areas and describe their procedures for assuring the accessibility and adequacy of care. Senate Bill 712 inserted similar language in § 32.1-137.2. The bill also deleted subsection C of § 38.2-4301 concerning notices of modifications of an HMO's operations. Additionally, the legislation added related language in § 38.2-5802 to require HMOs and other health carriers responsible for an MCHIP to make periodic filings describing the MCHIP's health care delivery system.

Subsection A of § 38.2-5802 requires health carriers and HMOs to include with their applications for initial and renewal licensure, material that describes and categorizes the health carrier's transactions and operations in this Commonwealth. Required disclosures should focus on factors that influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services through its MCHIPs. These provisions are currently applicable to entities seeking initial licensure as a health carrier under Title 38.2 of the Code of Virginia. All licensed health carriers will be required to include the descriptions and other disclosures prescribed by § 38.2-5802 A in the license renewal applications filed with the Bureau in 1999. Descriptions should reveal, for instance, the following:

- Type or types of organizations through which health care services are delivered; e.g., hospitals, physician groups, IPA, provider panels, etc., and whether each is an affiliate or non-affiliate.

- For each organization: the type of payment arrangements used to compensate providers; e.g., withholds, bonus payments, capitation, fee-for-service discounts, etc.

- The type and extent of out-of-network services, point of service products, indemnity products, and the actual percentages characterizing each.

- The actual and projected numbers of covered persons as compared to the size and amount of risk arising from the delivery of health care services.

- When and how premiums are paid for each plan; e.g., monthly or semi-annually; by employers on behalf of eligible employees, by employees, or by individual subscribers; or in accordance with medicaid or medicare provisions.

- A general description of the benefit payment differential incentive used for each type, group or category of providers.

- Whether and to what extent the health carrier does one or more of the following: provides, arranges for, pays for, or reimburses health care services.

- The types of risk management employed by the health carrier for any services delivered on a prepaid or insured basis.

- Incentive arrangements which are in addition to or have an impact on the identified payment arrangements.

- The identity and roles of all intermediaries in the chain of delivery of health care services under an MCHIP between the health carrier and the provider who actually interacts with the covered person.

The foregoing are illustrative examples. They are not definitive guidelines. Each HMO should develop descriptions which clearly explain its operations and which might also distinguish its transactions from those of other health carriers (HMOs and non-HMOs) operating MCHIPs. Description should clearly reveal revisions of information reported in the HMO's most recently filed annual statement concerning operations and organization and related parties.

Subsection D of § 38.2-5802 requires the Commission's prior approval for any changes which would result in operational changes that are materially at variance with the information required by § 38.2-5802 and filed with the Commission. The statute provides that a material change in the MCHIP's health care delivery system shall be deemed to result in such an operational change, and provides also that the Commission may determine that other changes are material. Therefore, a change in the service area may be viewed as a material change in the MCHIP's health care delivery system and subject to the Bureau's prior approval, if the change

materially affects the health carrier's financial operations in the manner described in this letter. It should be clarified that the Commission is no longer "approving" service areas and service area expansions. The Commission is, however, requiring prior approval for changes that would result in operational changes that are materially at variance with the information submitted to the Commission pursuant to § 38.2-5802, even if the change happens to be a service area change. The filing instructions set forth in this letter describe such changes.

HMOs are reminded that portions of § 38.2-4301 dealing with geographic areas and service area concerns that were deleted by Senate Bill 712 now appear in § 32.1-137.2 A. Also, it can be noted that § 38.2-5807 states that access to care shall be assessed by the VDH in accordance with provisions in Article 1.1 (§ 32.1-137.1 et seq.) of Chapter 5 of Title 32.1 concerning quality assurance. Health carriers, including HMOs, with questions concerning these filing requirements should contact the VDH's Center for Quality Health Care Services and Consumer Protection.

The filing instructions that follow and the material transaction checklist attached to this letter provide additional guidance for filings required under § 38.2-5802. The instructions include provisions for complying with the requirement at § 38.2-5802 E that each health carrier give notice to the State Health Commissioner of the filing it makes with the Commission pursuant to § 38.2-5802.

FILING INSTRUCTIONS

These filing instructions are applicable for the notices of material transaction required by section 38.2-5802 D of Chapter 58 of Title 38.2 of the Code of Virginia. They are significant for any "operational change," that is, any change in the manner in which a health carrier operates one or more MCHIPs.

1. As provided by statute, a health carrier shall file a request for approval prior to effecting a change which is materially at variance with information currently on file with the Commission. Health carriers shall be expected to consider the significance of anticipated changes and to seek prior approval of any change which can be reasonably identified as having a material impact at any time in the foreseeable future on an MCHIP's health care delivery system. The health carrier's decision not to seek prior approval must be supported by reasonable and documented consideration of materiality. Failure to file notice of a material change shall be deemed a violation of § 38.2-5802 D subject to penalty pursuant to § 38.2-218.

2. As a general guideline, changes requiring prior approval pursuant to § 38.2-5802 D include any change that increases or decreases, or is likely to increase or decrease, the health carrier's revenues, expenses, or net worth in an amount that exceeds 5% of the health carrier's current net worth. For a health carrier other than a health maintenance organization, net worth shall mean capital and surplus.

When evaluating an anticipated change, the health carrier shall project the impact of the change on total expenses, total revenues and net worth through the end of the current year, and also during each of the next two successive calendar years. If the projected impact on revenue, expenses or net worth in one of the three time periods includes an amount greater than 5% of the health carrier's current net worth, the change shall require prior approval. For purposes of this calculation, "current net worth" shall mean the health carrier's net worth as determined by the most recently filed annual or quarterly financial statement.

A "change" shall include and may result from any single transaction and also any series of transactions occurring within a 12-month period that are sufficiently similar in nature as to be reasonably construed as a single transaction or change. If the aggregate impact of such change on net worth, total revenue or total expenses may be projected to exceed 5% of the health carrier's current net worth, the series shall be deemed a material change subject to timely notice and prior approval.

3. The Commission may identify additional measures of materiality after considering the operating results and financial position of a health carrier.

4. As described in the appended "Material Transaction Checklist," the health carrier shall disclose and explain the proposed change in a statement that describes the change and its projected impact on operations. If requested by the Commission, the health carrier shall disclose also the detailed financial projections used to determine materiality.

5. An initial filing shall be made with the Financial Regulation Division of the Bureau and a duplicate introductory cover letter shall be sent to the Virginia Department of Health's Center for Quality Health Care Services and Consumer Protection (VDH). The cover letter shall contain all the information described in Part A of the appended "Material Transaction Checklist." The health carrier shall give adequate written notice to the VDH of any supplemental filings and amendments filed with the Bureau. Notice will be adequate when the health carrier provides the VDH with a copy of a transmitting cover letter containing the information described in Part A of the appended "Material Transaction Checklist."

6. Duplicate copies shall have original signatures.

7. Material to be filed with the State Health Commissioner or the VDH may be directed to:

Tom Bridenstine, Supervisor
Center for Quality Health Care Services & Consumer Protection
VIRGINIA DEPARTMENT OF HEALTH
Suite 216, 3600 West Broad Street
Richmond, VA 23230-4920
(804) 367-2370

Careful adherence to the procedures set forth in this Administrative Letter will be appreciated. Questions regarding the letter should be addressed in writing to:

Andy Delbridge, Supervisor
Company Licensing and Regulatory Compliance Section
Financial Regulation Division
SCC BUREAU OF INSURANCE
P. O. Box 1157
Richmond, VA 23218

Sincerely,

Alfred W. Gross
Commissioner of Insurance

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Attachment: "Material Transaction Checklist" (Appendix)

MATERIAL TRANSACTION CHECKLIST

Initial notice of an anticipated change shall include the material described in this checklist. Parts A and B shall be filed with the SCC Bureau of Insurance, Financial Regulation Division, Company Licensing and Regulatory Compliance Section., P. O. Box 1157, Richmond, VA 23218. A duplicate of the Part A cover letter should be provided to: The Virginia Department of Health, Center for Quality Health Care Services and Consumer Protection, Suite 216, 3600 W. Broad Street, Richmond, VA 23230-4920.

PART A: INTRODUCTORY COVER LETTER with general description of the proposed change. This cover letter should:

- Be addressed to the SCC Bureau of Insurance and directed to the Financial Regulation Division; the Virginia Department of Health's Center for Quality Care Health Services and Consumer Protection should be designated as receiving a copy.
- Identify the controlling statute.
- State the purpose of the filing.
- Briefly describe proposed change. Identify aspects of the delivery system which are subject to change, e.g., service area, provider contracts, numbers or types of providers, provider compensation structure, incentive arrangements. Comment on how the proposed change in the delivery system is projected to have a material impact on the financial condition of the health carrier.
- State the effective date of the proposed change.
- Provide the name and telephone number of a contact person.
- Be signed and dated by an officer or director of the health carrier.

PART B: STATEMENT OF PROJECTED IMPACT describing the proposed changes and fully disclosing their significance and materiality. At a minimum, the statement shall:

- Describe the reasons that change was determined to be material.
- Identify the elements of operations subject to change.
- Disclose the projected impact of change, in total, on expenses, revenues, and net worth through the end of the current year and each of the next two successive calendar years.
- Disclose the projected impact of change, if any, on the health carrier's statutory minimum net worth as projected for the current year and the next two successive years.
- Describe provider arrangements and include a schedule of provider contracts and network access agreements to be used to effect the proposed change. Non-standardized contracts and representative copies of any new or revised forms of contracts and agreements not currently on file with the Bureau shall be highlighted and attached to the listing.
- State why the change should be approved as proposed.

The Bureau may determine that additional information is necessary to secure full and accurate knowledge of the affairs and condition of the health carrier. Such additional information may include detailed financial projections and supportive schedules and statements documenting critical assumptions such as changes in enrollment, premium rates, provider reimbursement, utilization rates, risk-sharing arrangements, costs of long-term financing, and inflation.

NOTE: The Bureau will notify VDH of its determination with respect to each filing; and VDH has advised that it will notify the Bureau of any determination made or action taken with respect to any duplicate filing made in whole or in part with the Bureau.