# WEST VIRGINIA CODE: §33-16D-16

**§33-16D-16. Authorization of uninsured small group health benefit plans.**

(a) Upon filing with and approval by the commissioner, any carrier licensed pursuant to this chapter which accesses a health care provider network to deliver services may offer a health benefit plan and rates associated with the plan to a small employer subject to the conditions of this section and subject to the provisions of this article. The health benefit plan is subject to the following conditions:

(1) The health benefit plan may be offered by the carrier only to small employers which have not had a health benefit plan covering their employees for at least six consecutive months before the effective date of this section. After the passage of six months from the effective date of this section, the health benefit plan under this section may be offered by carriers only to small employers which have not had a health benefit plan covering their employees for twelve consecutive months;

(2) If a small employer covered by a health benefit plan offered pursuant to this section no longer meets the definition of a small employer as a result of an increase in eligible employees, that employer shall remain covered by the health benefit plan until the next annual renewal date;

(3) The small employer shall pay at least fifty percent of its employees' premium amount for individual employee coverage;

(4) The commissioner shall promulgate emergency rules under the provisions of article three, chapter twenty-nine-a of this code on or before September 1, 2004, to place additional restrictions upon the eligibility requirements for health benefit plans authorized by this section in order to prevent manipulation of eligibility criteria by small employers and otherwise implement the provisions of this section;

(5) Carriers must offer the health benefit plans issued pursuant to this section through one of their existing networks of health care providers;

(A) The Insurance Commission shall, on or before May 1, 2004, and each year thereafter, by regular mail, provide a written notice to all known in-state health care providers that:

(i) Informs the health care provider regarding the provisions of this section; and

(ii) Notifies the health care provider that if the health care provider does not give written refusal to the Insurance Commission within thirty days from receipt of the notice or the health care provider has not previously filed a written notice of refusal to participate, the health care provider must participate with and accept the products and provider reimbursements authorized pursuant to this section;

(B) The carrier's network of health care providers, as well as any health care provider which provides health care goods or services to beneficiaries of any departments or divisions of the state, as identified in article twenty-nine-d, chapter sixteen of this code, shall accept the health care provider reimbursement rates set pursuant to this section unless the health care provider gives written refusal to the Insurance Commission between May 1 and June 1 that the provider will not participate in this program for the next calendar year. Notwithstanding any provision of this code to the contrary, health care providers may not be mandated to participate in this program except under the opt-out provisions of subdivision (5), subsection (a) of this section and therefore the health care provider shall annually have the ability to file with the Insurance Commission written notice that the health care provider will not participate with products issued pursuant to this section. Once a health care provider has filed a notice of refusal with the Insurance Commission, the notice shall remain effective until rescinded by the provider and the provider shall not be required to renew the notice each year;

(C) Insurance Commission is responsible for receiving the responses, if any, from the health care providers that have elected not to participate and for providing a list to the commissioner of those health care providers that have elected not to participate;

(D) Those health care providers that do not file a notice of refusal shall be considered to have accepted participation in this program and to accept Public Employees Insurance Agency health care provider reimbursement rates for their services as set by this section;

(E) Health care provider reimbursement rates used by the carrier for a health benefit plan offered pursuant to this section shall have no effect on provider rates for other products offered by the carrier and most-favored-nation clauses do not apply to the rates;

(6) With respect to the health benefit plans authorized by this section, the carrier shall reimburse network health care providers at the same health care provider reimbursement rates in effect for the managed care and health maintenance organization plans offered by the West Virginia Public Employees Insurance Agency. Beginning in the year 2004, and in each year thereafter, the health care provider reimbursement rates set under this section may not be lowered from the level of the rates in effect on July 1 of that year for the managed care and health maintenance plans offered by the Public Employees Insurance Agency. While it is the intent of this paragraph to govern rates for plans offered pursuant to this section for annual periods, this subdivision in no way prevents the Public Employees Insurance Agency from making provider reimbursement rate adjustments to Public Employees Insurance Agency plans during the course of each year. If there is a dispute regarding the determination of appropriate rates pursuant to this section, the Director of the Public Employees Insurance Agency shall, in his or her sole discretion, specify the appropriate rate to be applied;

(A) The health care provider reimbursement rates as authorized by this section shall be accepted by the health care provider as payment in full for services or products provided to a person covered by a product authorized by this section;

(B) Except for the health care provider rates authorized under this section, a carrier's payment methodology, including copayments and deductibles and other conditions of coverage, remains unaffected by this section;

(C) The provisions of this section do not require the Public Employees Insurance Agency to give carriers access to the purchasing networks of the Public Employees Insurance Agency. The Public Employees Insurance Agency may enter into agreements with carriers offering health benefit plans under this section to permit the carrier, at its election, to participate in drug purchasing arrangements pursuant to article sixteen-c, chapter five of this code, including the multistate drug purchasing program. This paragraph provides authorization of the agreements pursuant to section four of said article;

(7) Carriers may not underwrite products authorized by this section more strictly than other small group policies governed by this article;

(8) With respect to health benefit plans authorized by this section, a carrier shall have a minimum anticipated loss ratio of seventy-seven percent to be eligible to make a rate increase request after the first year of providing a health benefit plan under this section;

(9) Products authorized under this section are exempt from the premium taxes assessed under sections fourteen and fourteen-a, article three of this chapter;

(10) A carrier may elect to nonrenew any health benefit plan to an eligible employer if, at any time, the carrier determines, by applying the same network criteria which it applies to other small employer health benefit plans, that it no longer has an adequate network of health care providers accessible for that eligible small employer. If the carrier makes a determination that an adequate network does not exist, the carrier has no obligation to obtain additional health care providers to establish an adequate network;

(11) Upon thirty days' advance notice to the commissioner, a carrier may, at any time, elect to nonrenew all health benefit plans issued pursuant to this section. If a carrier nonrenews all its business issued pursuant to this section for any reason other than the adequacy of the provider network, the carrier may not offer this health benefit plan to any eligible small employer for a period of at least two years after the last eligible small employer is nonrenewed; and

(12) The Insurance Commissioner may not approve any health benefit plan issued pursuant to this section until it has obtained any necessary federal governmental authorizations or waivers. The Insurance Commissioner shall apply for and obtain all necessary federal authorizations or waivers.

(b) Health benefit plans authorized by this section are not intended to violate the prohibition set out in subsection (a), section four of this article.

(c) Carriers offering health benefit plans pursuant to this section shall annually or before

December 1 of each year report in a form acceptable to the commissioner the number of health benefit plans written by the carrier and the number of individuals covered under the health benefit plans.

(d) To the extent that provisions of this section differ from those contained elsewhere in this chapter, the provisions of this section control.