WEST VIRGINIA CODE CHAPTER 33 ARTICLE 16D

§33-16D-1. Purpose of article.

The purpose of this article is to promote the availability of health insurance coverage to small employers, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group health insurance marketplace.

§33-16D-2. Definitions.

As used in this article:

(a) "Actuarial certification" means a written statement by an actuary, or other individual acceptable to the commissioner, that a small employer carrier is in compliance with the provisions of section five of this article, based upon that person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans.

(b) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(c) "Bona fide association" has the meaning set forth in section one-a, article sixteen of this chapter.

(d) "Case characteristics" mean demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, which are considered by the carrier in the determination of premium rates for the small employer. Claim experience, health status and duration of coverage since issue are not case characteristics for the purposes of this article.

(e) "Class of business" means all or any distinct grouping of small employers as shown on the records of the small employer carrier, which shall be subject to the following requirements:

(1) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans:

(A) Are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer carrier;

(B) Have been acquired from another small employer carrier as a distinct grouping of plans;

(C) Are provided through a bona fide association; or

(D) Are in a class of business that meets the requirements for exception to the restrictions related to premium rates provided in paragraph (A), subdivision (1), subsection (a), section five of this article.

(2) A small employer carrier may establish no more than two

additional groupings under subdivision (1) of this subsection on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

(3) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

(f) "Commissioner" means the Insurance Commissioner of West Virginia.

(g) "Creditable coverage" has the meaning set forth in section one-a, article sixteen of this chapter.

(h) "Dependent" has the meaning set forth in section one-a, article sixteen of this chapter.

(i) "Group health plan" has the meaning set forth in section one-a, article sixteen of this chapter.

(j) "Health benefit plan" has the meaning set forth in section one-a, article sixteen of this chapter.

(k) "Health status-related factor" has the meaning set forth in section one-a, article sixteen of this chapter.

(l) "Index rate" means for each class of business for small employers with similar case characteristics the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(m) "Medical care" has the meaning set forth in section one-a, article sixteen of this chapter.

(n) "Network plan" has the meaning set forth in section one-a, article sixteen of this chapter.

(o) "New business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(p) "Preexisting condition exclusion" has the meaning set forth in section one-a, article sixteen of this chapter.

(q) "Rating period" means the calendar period of at least twelve months for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(r) "Small employer" means any person, firm, corporation, partnership or association actively engaged in business in the State of West Virginia who, during the preceding calendar year, employed an average of no more than fifty but not fewer than two eligible employees and employs at least two employees on the first day of its group health plan year. A new employer, not in existence for all of the preceding calendar year, shall be considered a small employer if it is reasonably expected to employ an average of no more than fifty but not

fewer than two eligible employees on business days in the current calendar year. Companies which are affiliated companies or which are eligible to file a combined tax return for state tax purposes shall be considered one employer.

(s) "Small employer carrier" or "carrier" means any health insurer, as defined in section one-a, article sixteen of this chapter, which offers health benefit plans covering the employees of a small employer situate within the State of West Virginia.

§33-16D-3. Health insurance plans subject to this article.

The provisions of this article apply to any health benefit plan which provides coverage to one or more eligible employees of a small employer situate in the State of West Virginia: Provided, That the provisions of this article shall not apply to individual health insurance policies which are subject to policy form and premium rate approval as required by article sixteen-b of this chapter.

§33-16D-4. Discrimination prohibited; guaranteed issue; filing with commissioner; violations and penalties.

(a) All carriers subject to this article are strictly prohibited from marketing their product to a specific group, legal occupation, locale, zip code, neighborhood, race, religion, or any discriminatory group.

(b) For plan years beginning after June 30, 1997, in which the plan has, on the first day of the plan year, at least two enrollees who are current employees, each carrier shall accept every small employer that applies for coverage under a health benefit plan, unless such health benefit plan is made available only through a bona fide association, and consistent with public law 104-191 (Public Health Service Act section 2711 (a) (1) (B)), shall accept for enrollment in the plan every employee of the small employer, including dependents, when an employee or dependent first becomes eligible to enroll under terms of the plan and under the rules of the carrier that are uniformly applicable to small employers. This subsection shall not apply to:

(1) A network plan if the carrier:

(A) Limits coverage to a small employer's employees and dependents who reside, live or work in the carrier's service area; or

(B) Obtains the commissioner's approval to deny coverage in its service area due to the carrier's lack of capacity for additional enrollees, but only if the carrier denies coverage uniformly to all small employers without regard to their claims experience or that of their employees and dependents or to any health status-related factor relating to employees and their dependents. A carrier may not offer small group coverage in the same service area for one hundred eighty days after the date coverage is denied under this paragraph; or

(2) A carrier that obtains the commissioner's approval to deny coverage due to the carrier's insufficient financial reserves for additional coverage, but only if the carrier denies coverage uniformly to all small employers, consistent with all requirements of this chapter and without regard to the claims experience of the small employers and their employees and dependents or to any health status-related factor relating to employees and their dependents. A carrier may not offer small group coverage for one hundred eighty days after the date coverage is denied under this subdivision or until the carrier has obtained the commissioner's approval of the level of its reserves for additional coverage, whichever is later.

(c) All carriers subject to this article shall file any marketing information upon request of the commissioner. The commissioner shall review said information and shall have the authority to take appropriate action to eliminate discriminatory marketing practices, including imposing fines on violators of this section of not more than $10,000. Upon a second violation of this section, the commissioner shall have the authority to revoke the violator's license to transact insurance.

§33-16D-5. Premium rates for small employers; classes; maximum rates; eligibility for rate increases.

(a) Premium rates for health benefit plans subject to this article shall be subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent: Provided, That this subdivision shall not apply to a class of business if all of the following apply:

(A) The class of business is one for which the carrier does not reject, and never has rejected, small employers included within the definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claim experience or health status;

(B) The carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the class of business; and

(C) The class of business is currently available for purchase.

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than thirty percent of the index rate.

(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;

(B) An adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business; and

(C) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(4) In the case of health benefit plans issued prior to the effective date of this article, a premium rate for a rating period may exceed the ranges described in subdivision (1) or (2) of this subsection for a period of five years following the effective date of this article. In that case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(A) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

(B) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(b) Nothing in this section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

(c) Adjustments in rates for claim experience, health status and duration of coverage may not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(d) A small employer carrier shall utilize industry as a case characteristic in establishing premium rates: Provided, That the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than fifteen percent.

(e) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(f) A small employer carrier may not involuntarily transfer a small employer into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration since issue.

(g) To be eligible to make a rate increase request after July 1, 1993, a carrier shall have a minimum anticipated loss ratio of seventy-three percent. In calculating its minimum anticipated loss ratio, an insurer shall include in its actual incurred claims the amount of premium taxes for the same experience period which are attributable to the policy forms or certificates affected by this section and which were paid to the State of West Virginia pursuant to the provisions of article three of this chapter.

(h) All insurance carriers subject to this article, effective July 1, 1993, shall be prohibited from distinguishing more than four classes of business within its small group insurance coverage.

(i) If any health benefit plan is provided by a carrier through a bona fide association of small employers not in the business of selling insurance and with not fewer than two hundred cumulative employees, and if such association is rated on the basis of the number of employees and not on the basis of the individual small employers, such association or group is exempt from the provisions of this article.

§33-16D-6. Insurance commissioner to promulgate rules.

Pursuant to chapter twenty-nine-a of this code, the Insurance Commissioner may promulgate rules necessary to implement the provisions of this article.

§33-16D-7. Renewability of coverage; exceptions.

(a) A health benefit plan subject to this article shall be renewable to all eligible employees at the option of the small employer: Provided, That a carrier may refuse to renew a health benefit plan for plan years beginning on or before June 30, 1997, for any of the following reasons:

(1) Nonpayment of required premiums;

(2) Fraud or misrepresentation by the small employer or by the insured individual;

(3) Noncompliance with plan provisions;

(4) The number of individuals covered under the plan is fewer than the number or less than the percentage of eligible individuals necessary pursuant to the percentage requirements under the plan; or

(5) The small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

(b) For plan years beginning after June 30, 1997, in which the plan has, on the first day of the plan year, at least two enrollees who are current employees, a health benefit plan shall be renewable to all eligible employees at the option of the small employer, and a carrier may refuse to renew a health benefit plan only for one of the following reasons:

(1) Nonpayment of required premiums;

(2) Fraud or misrepresentation of material fact by the small employer;

(3) The number of individuals covered under the plan is fewer than the number or less than the percentage of eligible individuals necessary pursuant to the percentage requirements under the plan;

(4) The carrier ceases to offer health benefit plans to small employers as provided in subsection (d) of this section;

(5) For coverage offered under a network plan, a carrier no longer has any enrollees of the network plan who live or work in the plan's service area, and the carrier would deny coverage under the network plan to a small employer with no eligible employees or dependents in its service area; or

(6) For health benefit plans offered only through a bona fide association, the small employer ceases to be a member of the association, if plans are terminated uniformly without respect to any health status-related factor relating to any covered employee, association member or dependent. With respect to coverage provided to a small employer only through a bona fide association, a reference to "policyholder" or "plan sponsor" is deemed to include a reference

to the small employer.

(c)(1) For plan years beginning on or before June 30, 1997, a small employer carrier may cease to renew all plans under a class of business. Upon the small employer's election of nonrenewal, the carrier shall provide notice of such election not to renew to all affected health benefit plans and to the commissioner in each state in which an affected insured individual is known to reside at least ninety days prior to termination of coverage.

(2)A carrier which exercises its right to cease to renew all plans in a class of business pursuant to this subsection may not:

(A) Establish a new class of business for a period of five years after the nonrenewal of the plans without prior approval of the commissioner; or

(B) Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the carrier offers to transfer or provide coverage to all affected employers and eligible employees without regard to case characteristics, claim experience, health status or duration of coverage.

(d) For plan years beginning after June 30, 1997, in which the plan has, on the first day of the plan year, at least two enrollees who are current employees, a carrier may elect to discontinue offering health benefit plans:

(1) Of a particular type, if the carrier gives notice to each small employer affected and to all covered employees and dependents at least ninety days before the date coverage is discontinued. The carrier shall offer each such small employer the option to purchase all other health benefit plans offered by the carrier to small employers. In electing to discontinue health benefit plans of a particular type and in offering coverage under the preceding sentence, the carrier shall act uniformly without regard to small employers' claims experience or any health status-related factor relating to any covered employee or dependent or new employees or dependents who may become eligible for coverage; or

(2) Of all types if the carrier gives notice to the commissioner, to each small employer affected and to all covered employees or members and dependents at least one hundred eighty days before the date such plans are discontinued. The carrier shall discontinue all, and not renew any, health benefit plans in the small group market. The carrier may not issue any health benefit plan to a small employer in this state for a five-year period beginning on the date the last discontinued health benefit plan is not renewed.

(e) For plan years beginning after June 30, 1997, in which the plan has, on the first day of the plan year, at least two enrollees who are current employees, a carrier may modify a health benefit plan upon its renewal only if the modification is consistent with the provisions of this article and effective on a uniform basis among all individuals with that policy form. Except for coverage available only through an association, any modification shall be made effective on a uniform basis among all small employers with that product.

§33-16D-8. Disclosure of rating practices, renewability provisions and availability of health benefit plans.

(a) Each small employer carrier shall make reasonable disclosure in solicitation and sales materials provided to small employers of the following:

(1) The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status or duration of coverage of the employees of the small employer;

(2) The provisions concerning the carrier's right to change premium rates and the factors, including case characteristics, which affect changes in premium rates;

(3) A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans and the benefits and premiums available under all health benefit plans for which the small employer is qualified;

(4) The provisions relating to renewability of coverage;

(5) The provisions relating to any preexisting conditions limitations; and

(6) An explanation, if applicable, that the small employer is purchasing a minimum benefits plan issued pursuant to article sixteen-c of this chapter.

(b) All disclosure statements shall be presented in clear and understandable form and format and shall be separate from any policy, certificate or evidence of coverage otherwise provided. No carrier may be required under this section to disclose proprietary or trade secret information to a small employer.

§33-16D-9. Maintenance of records.

(a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are based upon commonly accepted actuarial principles.

(b) Each small employer carrier shall file each first day of March with the commissioner an actuarial certification that the carrier is in compliance with the provisions of section five of this article and that the rating methods of the carrier are actuarially sound. A copy of such certification shall be retained by the carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subsection (a) of this section available to the commissioner upon request.

§33-16D-10. Suspension of requirements.

The commissioner may suspend all or part of the requirements of this article, other than sections four, seven, eight and twelve, applicable to one or more health benefit plans for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

§33-16D-11. Effective date.

Except as otherwise provided, the provisions of this article shall apply to each health benefit plan for a small employer situate in the State of West Virginia that is delivered, issued for delivery, renewed or continued after the effective date of this article. For purposes of this section, the date a plan is continued is the first rating period which commences after the effective date of this article.

§33-16D-12. Equality of terms; preexisting conditions; continuous coverage restrictions, eligibility for enrollment.

Health benefit plans and, to the extent permitted by the federal Employee Retirement Income Security Act (ERISA), other benefit arrangements covering small employers shall be subject to the following provisions:

(a) Preexisting conditions provisions may not exclude coverage for a period beyond twelve months following an individual's effective date of coverage and may only relate to conditions which had, during the twelve months immediately preceding the effective date of coverage, manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received, or as to a pregnancy existing on the effective day of coverage. For plan years beginning after June 30, 1997, in which the plan has, on the first day of the plan year, at least two enrollees who are current employees, a health benefit plan shall meet all requirements set forth in section three-k, article sixteen of this chapter (preexisting condition exclusions).

(b) In determining whether a preexisting condition limitation provision applies to an eligible employee or dependent, all health benefit plans shall credit the time such person was covered under a previous employer-based health benefit plan, a comparable individual health benefit plan, or a self-insured plan if the previous coverage was continuous to a date not more than thirty days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan. For plan years beginning after June 30, 1997, in which the plan has, on the first day of the plan year, at least two enrollees who are current employees, a health benefit plan shall meet all requirements set forth in section three-m, article sixteen of this chapter (creditable coverage).

(c) Subject to subsections (a) and (b) of this section, when a small group employer converts its health benefit plan from one health benefit plan to another health benefit plan or from one carrier to another carrier, all eligible employees who at the time of conversion are covered by the health benefit plan shall be offered health benefits coverage under the subsequent plan, and no employee who at the time of conversion is covered by a health benefit plan offered by said employer may be treated any differently relative to other covered employees under the new health benefit plan than he or she is treated under the current health benefit plan.

(d) For plan years beginning after June 30, 1997, in which the plan has, on the first day of the plan year, at least two enrollees who are current employees, no carrier may condition eligibility or continued eligibility of any employee or dependent on a health status-related factor, and a health benefit plan shall meet all requirements set forth in section three-n, article sixteen of this chapter (eligibility for enrollment).

§33-16D-13. Obligations of employer; discrimination as to benefits paid.

Any employer subscribing to a health care benefit plan for or on behalf of its employees pursuant to this chapter shall not discriminate against any eligible employee on the basis of such employee's status with the employer by paying for all or part of the health care benefit plan premiums in a manner different from that provided any other eligible employee: Provided, That any participating small employer must pay at least twenty-five percent of each eligible employee's health care benefit plan premiums.

§33-16D-14. Child immunization services coverage.

All policies issued pursuant to this article shall cover the cost of child immunization services as described in section five, article three, chapter sixteen of this code, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration. These services shall be exempt from any deductible, per-visit charge and/or copayment provisions which may be in force in these policies or contracts. This section does not require that other health care services provided at the time of immunization be exempt from any deductible and/or copayment provisions.

§33-16D-15. Continuation of coverage under small plans.

The Legislature finds that the provisions of this article do not address continuing coverage under a health benefit plan. Therefore, the commissioner is to perform or have performed a study to determine the feasibility and advisability of implementing continuation of coverage under health benefit plans issued to small employers with fewer than twenty employees. The commissioner shall make a report of findings, conclusions and recommendations to the Legislature during its regular session in the year one thousand nine hundred ninety-eight.

§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.