WEST VIRGINIA LEGISLATURE

REGULAR SESSION, 1991

ENROLLED

Revised Com. Sub. for Com. Sub. for

SENATE BILL NO. 535

(Originating in the Committee

(~~By Senator~~ on Finance)

PASSED March 9, **1991**

In Effect July 1, 1991 ~~Passage~~

ENROLLED

REVISED

COMMITTEE SUBSTITUTE

FOR

COMMITTEE SUBSTITUTE

FOR

Senate Bill No. 535

(Originating in the Committee on Finance)

[Passed March 9, 1991; to take effect July 1, 1991.]

AN ACT to amend chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, by adding thereto three new articles, designated articles six-c, sixteen-c and sixteen-d; to amend article fifteen of said chapter by adding thereto a new section, designated section fourteen; to amend and reenact section four, article twenty-four; section six, article twenty-five; and section twenty-four, article twenty-five-a of said chapter, all relating to individual and employer group accident and sickness insurance policies; establishing a guaranteed loss ratio for insurers of individual policies; definition of terms; establishment of guaranteed loss ratio by insurance commissioner; calculation of ratios; minimum rates; participation and review; duties of insurance commissioner; allowing the insurance commissioner to promulgate rules; form of guarantees; provisions of guarantee; refunds of premi-

ums; disclosure; rejection of guarantees, notice and hearing; establishment of minimum benefits and coverages for individual accident and sickness insurance policies by insurance commissioner; basic benefits; exemptions; regulating employer group accident and sickness insurance policies; declaration of findings and purpose; defining terms; exempting insurance policies issued pursuant to this article from including certain benefits otherwise mandated by law; designating minimum benefits and coverages required in such policies; permitting insurers to offer optional or other benefits; permitting deductibles and copayments; insurance commissioner establishing minimum benefits and coverages; basic policy benefits; requiring certain policy provisions; prohibiting discrimination; requiring an insurer to disclose specified information to an eligible employee upon offering coverage pursuant to this article; requiring certain written acknowledgments by eligible employees members who apply for such coverage; requiring certification by employer; permitting insurance commissioner to promulgate rules; creating exemptions from premium tax; authorizing the insurance commissioner to review and approve all marketing communication used to market insurance policies issued to small employers; defining applicable terms; plans subject to this article and exceptions; application of article; prohibiting discrimination in marketing; requiring insurers issuing such policies to maintain records and file annual reports with the insurance commissioner; establishing premium rates, classes of employers, maximum rates and eligibility for rate increases; authorizing the insurance commissioner to promulgate rules; regarding renewability of coverage and exceptions; disclosure requirements; suspension of requirements; effective date; equality of terms; pre-existing conditions; restrictions; benefits upon conversion; obligations of employers; and applying said provisions to certain health care insurers or providers.

Be it enacted by the Legislature of West Virginia:

That chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be

amended by adding thereto three new articles, designated articles six-c, sixteen-c and sixteen-d; that article fifteen of said chapter be amended by adding thereto a new section, designated section fourteen; and that section four, article twenty-four; section six, article twenty-five; and section twenty-four, article twenty-five-a of said chapter, be amended and reenacted, all to read as follows:

ARTICLE 6C. GUARANTEED LOSS RATIOS AS APPLIED TO INDIVIDUAL SICKNESS AND ACCIDENT INSURANCE POLICIES.

§33-6C-1. Loss ratio guarantees; definitions.

As used in this article:

(a) "Commissioner" means the insurance commissioner of West Virginia;

(b) "Experience period" means, for any given rate filing for which a loss ratio guarantee is made, the period beginning on the first day of the calendar year during which the guaranteed rates first take effect and ending on the last day of the calendar year during which the insurer earns one million dollars in premiums on the form in West Virginia or, if the annual premium earned on the form in West Virginia is less than one million dollars, earns nationally;

(c) "Form" means individual sickness and accident policy forms of any insurer offering such benefits;

(d) "Loss ratio" means the ratio of incurred claims to earned premium; and

(e) "Successive experience period" means the experience period beginning on the first day following the end of the preceding experience period.

§33-6C-2. Insurance commissioner to establish guaranteed loss ratios; minimum rates; participation by insurer; calculation of ratios; minimum rate; application.

(a) The insurance commissioner shall establish a guaranteed loss ratio which may be implemented by any insurer offering individual sickness and accident

insurance policies. The loss ratios shall be calculated by the commissioner and each individual insurer and shall be based upon studies and relevant information collected from various sources, including, but not limited to, the health care cost review authority and the national association of insurance commissioner's rate filing guidelines: *Provided,* That the guaranteed loss ratio shall not be less than fifty-five percent. The guaranteed loss ratio for each insurer shall be published by the insurance commissioner in the register maintained by the secretary of state.

(b) The guaranteed loss ratio shall be based upon experience periods during which the insurer earns one million dollars in premium in West Virginia: *Provided,* That if the annual earned premium volume in West Virginia is less than one million dollars, the loss ratio guarantee shall be based on such other actuarially sound methods as the commissioner may determine are appropriate, including, but not limited to, the actual nationwide loss ratios: *Provided, however,* That if the aggregate earned premium for all states is less than one million dollars, the experience period will be extended until the end of the calendar year in which one million dollars of earned premium is attained.

(c) Any insurer may apply to the commissioner to operate on a guaranteed loss ratio basis. The insurance commissioner shall review each application and, in his or her discretion, approve or reject the same. Any insurer approved by the commissioner shall be exempt from filing rate increase applications as required by the commissioner and other provisions of this chapter.

§33-6C-3. Duties of insurance commissioner; promulgation of rules.

(a) The insurance commissioner shall promulgate rules and regulations pursuant to chapter twenty-nine-a of this code establishing procedures for implementing the provisions of this article.

(b) The commissioner shall have the authority to examine the records and files of any insurer to determine compliance with the provisions of this

article, the costs of which such examination shall be borne by the insurer.

(c) The insurance commissioner shall develop all forms, contracts or other documents to be used for the purposes outlined in this article.

§33-6C-4. Form of guarantee; requirements.

(a) Individual sickness and accident policy benefits under a policy form shall be deemed reasonable in relation to the premium charged, as required by paragraph (e), section nine, article six of this chapter, if the premium rates are filed pursuant to a loss ratio guarantee which meets the requirements of this article. The insurance commissioner shall not withdraw approval of a form on the grounds that benefits are unreasonable in relation to premiums charged so long as the insurer complies with the terms of the loss ratio guarantee.

(b) Each insurer of individual sickness and accident policy benefits shall execute and deliver to the insurance commissioner a loss ratio guarantee, to be provided by the commissioner, which guarantee shall be signed by an officer of the insurer.

(c) Each loss ratio guarantee shall contain, at a minimum, the following:

(1) A recitation of the anticipated lifetime and durational target loss ratios contained in the original actuarial memorandum filed with the policy form when it was originally approved;

(2) A guarantee that the actual West Virginia loss ratios for the experience period in which the new rates take effect, and for each experience period thereafter until new rates are filed, will meet or exceed the anticipated lifetime and durational target loss ratios contained in the original actuarial memorandum noted above;

(3) A guarantee that the actual West Virginia, or, if applicable, national, loss ratio results for the experience period at issue will be independently audited at

the insurer's expense; that such audit will be completed in the second quarter of the year following the end of the experience period; and that the results of such audit will be reported to the insurance commissioner not later than the thirtieth day of June following the end of the experience period;

(4) A guarantee that if the actual loss ratio during an experience period is less than the anticipated loss ratio for that period, then West Virginia policyholders will receive a proportional refund based on premium earned, which refunds shall be calculated and paid pursuant to section thirty-nine of this article; and

(5) A guarantee that the insurer does not engage in any discriminatory practices prohibited by section four, article eleven of this chapter or any such practice which discriminates against any individual on the basis of his or her legal occupation, race, religion or residence.

§33-6C-5. Premium refunds; calculation of the same; payments.

(a) Refunds to West Virginia policyholders made pursuant to section four of this article and based upon annual earned premium volume in West Virginia shall be calculated by multiplying the anticipated loss ratio by the applicable earned premium during the experience period and subtracting from that result the actual incurred claims during the experience period.

(b) Refunds to West Virginia policyholders made pursuant to section four of this article and based upon national annual earned premium volume shall be calculated by:

(1) Multiplying the anticipated loss ratio by the applicable earned premium during the experience period and subtracting from that result the actual incurred claims during the experience period; and

(2) Multiplying the results of subsection (1) by the total earned premium during the experience period from all West Virginia policyholders eligible for refunds; and

(3) Dividing the results of subsection (2) by the total earned premium during that period in all states on the policy form.

(c) Refunds must be made to all West Virginia policyholders who are insured under the applicable policy form as of the last day of the experience period. Such refund shall include interest, at the current accident and health reserve interest rate established by the national association of insurance commissioners, from the end of the experience period until the date of payment. Payment shall be made during the third quarter of the year following the experience period for which a refund is determined to be due.

(d) Refunds of less than ten dollars shall be aggregated and held by the insurer in a policyholders' liability fund and shall be used to offset any future rate increases.

§33-6C-6. Disclosure of rating practices; renewability provisions.

Each insurer providing individual sickness and accident policy benefits shall make reasonable disclosure in solicitation and sales materials provided to individuals of the following:

(a) The extent to which premium rates for individuals are established or adjusted according to the claim experience, health status or duration of coverage of the individual or his or her dependents;

(b) Provisions concerning the insurer's right to change premium rates and factors, including case characteristics, which affect changes in premium rates;

(c) A description of the class of insureds to which the individual is or will be included; and

(d) Provisions relating to renewability of coverage.

§33-6C-7. Rejection of guarantees; notice; hearing.

(a) The insurance commissioner may reject any loss ratio guarantee filed by an insurer within sixty days

from the date on which it was filed for any of the following reasons:

(1) The insurer has demonstrated an inability to adequately monitor its loss ratios;

(2) The insurer has failed to take timely rate increases in accordance with sound actuarial principles during the three-year period prior to filing the loss ratio guarantee;

(3) The insurer has not complied with the terms of a previously filed loss ratio guarantee;

(4) The insurer has submitted false, misleading or fraudulent material or information to the commissioner;

(5) The insurer is impaired, insolvent or such other similar financial condition as defined in article ten or any other article of this chapter; or

(6) Such other criteria as the commissioner, by legislative rule or regulation, may determine is appropriate.

(b) The insurance commissioner may reject or cancel any loss ratio guarantee filed by an insurer which had been previously approved if, upon review and investigation, the commissioner determines that the insurer has not complied with the provisions of the guarantee or this article.

(c) In the event a newly submitted loss ratio guarantee is rejected, the commissioner shall, within sixty days after the date the loss ratio guarantee was filed, mail notice of the rejection to the insurer. In the event an existing or previously approved loss ratio guarantee is cancelled, the commissioner shall mail notice of the rejection or cancellation to the insurer within fifteen days of the decision to cancel. In either situation, the insurer may, within ten days of being notified of its rejection or cancellation, request a hearing before the commissioner, which hearing shall be held within forty-five days from the date the request is made.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-14. Insurance commissioner to establish minimum benefits and coverages for an individual policy design; basic policy benefits; exemptions.

(a) The insurance commissioner shall establish minimum benefits which may be included in any individual accident and sickness insurance policy issued pursuant to this article. The commissioner may accept bids on designs for such minimum plans and shall compile a final basic benefit plan for use by insurers within six months after the effective date of this article.

(b) The basic policy plan established by the insurance commissioner may include coverage for the services of medical physicians or surgeons, podiatrists, physician assistants, osteopathic physicians or surgeons, chiropractors, midwives, advanced nurse practitioners, or any other professional health care provider as deemed appropriate by the insurance commissioner.

(c) The following shall serve as a guide to the commissioner in the design of a basic policy issued pursuant to this article:

(1) Inpatient hospital care up to twenty days per year;

(2) Outpatient hospital care including, but not limited to, surgery and anesthesia, pre-admission testing, radiation therapy and chemotherapy;

(3) Accident or emergency care through emergency room care and emergency admissions to a hospital;

(4) Physician office visits for primary, preventive, well, acute or sick care, up to four visits per year, and laboratory fees, surgery and anesthesia, diagnostic X-rays, physician care in a hospital inpatient or outpatient setting;

(5) Prenatal care, including a minimum of one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month

during the seventh and eighth months of pregnancy, and one office visit per week during the ninth month and until term. Coverage for each such visit shall include necessary appropriate screening, including history, physical examination, and such laboratory and diagnostic procedures as may be deemed appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member. Coverage for each office visit shall also include such prenatal counseling as the physician deems appropriate;

(6) Obstetrical care, including physician's services, delivery room and other medically necessary hospital services; and

(7) X-ray and laboratory services in connection with mammograms or pap smears when performed for cancer screening or diagnostic purposes, at the direction of a physician, including, but not limited to, the following:

(A) Baseline or other recommended mammograms for women age thirty-five to thirty-nine, inclusive;

(B) Mammograms recommended or required for women age forty to forty-nine, inclusive, every two years or as needed;

(C) A mammogram every year for women age fifty and over;

(D) A pap smear annually or more frequently based on the woman's physician's recommendation for women age eighteen or over. A basic policy issued pursuant to this article may apply to mammograms or pap smears the same deductibles or copayments as apply to other covered services.

(d) Notwithstanding any other provision of this code to the contrary, any basic policy issued pursuant to this section shall be exempt from all statutorily and regulatorily mandated benefits and coverages except for the minimum benefits and coverages as established by the commissioner pursuant to subsection (a) of this section.

(e) Nothing in this section shall preclude an insurer from offering any other benefit or coverage under a basic policy issued pursuant to this article, for an appropriate additional premium.

(f) A basic policy issued pursuant to this section may include deductibles, copayments and maximum benefits.

(g) The insurance commissioner shall promulgate legislative rules pursuant to chapter twenty-nine-a of this code to implement the provisions of this section, including, but not limited to, rules regarding bids, forms and rates.

(h) The premiums paid for insurance provided pursuant to this article shall be exempt from the premium tax required to be paid pursuant to sections fourteen and fourteen-a, article three of this chapter.

ARTICLE 16C. EMPLOYER GROUP ACCIDENT AND SICKNESS INSURANCE POLICIES.

§33-16C-1. Findings and purpose.

(a) The Legislature finds that the cost of group accident and sickness insurance is becoming unaffordable to many employers and their employees. Further, because of the unaffordability of this type of insurance, in some cases due to the cost of mandated benefits, a significant segment of the state's working population is unable to pay for many health care services.

(b) It is the purpose and intent of this article to authorize a program whereby employers may obtain affordable group accident and sickness insurance for currently uninsured employees that will increase access to health care, assist in the reduction of the amount of uncompensated care, and reduce the number of uninsured persons in this state.

§33-16C-2. Definitions.

As used in this article:

(a) "Basic policy" means a group accident and

sickness insurance contract for medical, surgical or hospital care that is required to contain only those minimum benefits and coverages mandated by this article, but which may contain other benefits and coverages.

(b) "Commissioner" means the insurance commissioner of West Virginia.

(c) "Department" means the department of insurance.

(d) "Eligible employee" means an employee who is employed by the employer for an average of at least twenty hours per week; includes individuals who are sole proprietors, general partners and limited partners; and includes individuals who either work or reside in this state.

(e) "Eligible employer" means a corporation, partnership or proprietorship which has done business in this state for at least one year.

(f) "Family member" means an eligible employee's spouse and any dependent child or stepchild under the age of eighteen or under age twenty-three if a full-time student at an accredited school: *Provided,* That the spouse, child or stepchild is not eligible for medicare, medicaid or state medical assistance.

(g) "Insurer" means any of the following entities that holds a valid certificate of authority from the commissioner: An insurance company authorized to transact accident and sickness insurance; a hospital service corporation, medical service corporation or health service corporation organized pursuant to article twenty-four of this chapter; a health care corporation organized pursuant to article twenty-five of this chapter; or a health maintenance organization organized pursuant to article twenty-five-a of this chapter.

(h) "Premium" means the consideration for insurance, by whatever name called.

§33-16C-3. Exemption from mandatory benefits and coverages; optional benefits and coverages; deductibles and copayments.

(a) Notwithstanding any other provision of this code to the contrary, any basic policy issued pursuant to this article shall be exempt from all statutorily and regulatorily mandated benefits and coverages except for the minimum benefits and coverages provided for in section four of this article.

(b) Nothing in this article shall preclude an insurer from offering any other benefit or coverage under a basic policy issued pursuant to this article, for an appropriate additional premium.

(c) A basic policy issued pursuant to this article may include deductibles, copayments and maximum benefits.

§33-16C-4. Insurance commissioner to establish minimum benefits and coverages; basic policy benefits.

(a) The insurance commissioner shall establish minimum benefits which shall be included in every insurance policy issued pursuant to this article. The commissioner may accept bids on designs for such minimum plans and shall compile a final basic benefit plan for use by insurers within six months after the effective date of this article.

(b) The basic policy plan established by the insurance commissioner may include coverage for the services of medical physicians or surgeons, podiatrists, physician assistants, osteopathic physicians or surgeons, chiropractors, midwives, advanced nurse practitioners, or any other professional health care provider as deemed appropriate by the insurance commissioner.

(c) The following shall serve as a guide to the commissioner in the design of a basic policy issued pursuant to this article:

(1) Inpatient hospital care up to twenty days per year;

(2) Outpatient hospital care including, but not

limited to, surgery and anesthesia, pre-admission testing, radiation therapy and chemotherapy;

(3) Accident or emergency care through emergency room care and emergency admissions to a hospital;

(4) Physician office visits for primary, preventive, well, acute or sick care, up to four visits per year, and laboratory fees, surgery and anesthesia, diagnostic X-rays, physician care in a hospital inpatient or outpatient setting;

(5) Prenatal care, including a minimum of one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy, and one office visit per week during the ninth month and until term. Coverage for each such visit shall include necessary appropriate screening, including history, physical examination, and such laboratory and diagnostic procedures as may be deemed appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member. Coverage for each office visit shall also include such prenatal counseling as the physician deems appropriate;

(6) Obstetrical care, including physician's services, delivery room and other medically necessary hospital services; and

(7) X-ray and laboratory services in connection with mammograms or pap smears when performed for cancer screening or diagnostic purposes, at the direction of a physician, including, but not limited to, the following:

(A) Baseline or other recommended mammograms for women age thirty-five to thirty-nine, inclusive;

(B) Mammograms recommended or required for women age forty to forty-nine, inclusive, every two years or as needed;

(C) A mammogram every year for women age fifty and over; or

(D) A pap smear annually or more frequently based on the woman's physician's recommendation for women age eighteen or over. A basic policy issued pursuant to this article may apply to mammograms or pap smears the same deductibles or copayments as apply to other covered services.

§33-16C-5. Required policy provisions.

(a) Each basic policy issued pursuant to this article shall contain in substance the following:

(1) A provision that the entire contract between the parties shall consist of the policy; the application of an eligible employer for such a policy, a copy of which shall be attached to such policy; and the individual applications, if any, submitted in connection with such policy by eligible employees or family members; and further that all statements made by any applicant shall be deemed representations and not warranties, and that no such statements shall void the insurance or reduce benefits thereunder unless contained in a written application;

(2) A provision that the insurer will furnish to the eligible employer, for delivery to each eligible employee of the insured group, an individual certificate setting forth in substance the essential features of the insurance coverage of such eligible employee and, if applicable, his or her family members, and to whom benefits thereunder are payable. If family members are included in the coverage, only one certificate need be issued for each family;

(3) A provision that all new eligible employees in the groups or classes eligible for insurance shall from time to time be added to such groups or classes eligible to obtain such insurance in accordance with the terms of the policy.

(b) No provision relative to notice, proof of loss, the time for paying benefits, or the time within which suit may be brought upon a basic policy issued pursuant to this article shall be less favorable to an eligible employee than would be permitted in the case of an

individual policy by the provisions set forth in article fifteen of this chapter.

§33-16C-6. Prohibitions against discrimination in establishing rates, terms or conditions.

Discrimination between individuals of the same class of risk in the issuance of basic policies, in the amount of premiums or rates charged for any insurance covered by this article, in benefits payable thereon, in any of the terms or conditions of the basic policy issued pursuant to this article, or in any other manner whatsoever, is prohibited. Nothing in this section shall prohibit an insurer from providing incentives for eligible employees or family members to utilize the services of a particular hospital or other health care provider.

§33-16C-7. Disclosures to eligible employees.

(a) Upon offering coverage under a basic policy issued pursuant to this article, the insurer shall provide the eligible employee with a written disclosure statement containing at least the following:

(1) An explanation of benefits otherwise mandated by state law and not covered by the basic policy;

(2) An explanation of cost control features of the basic policy, along with all appropriate mailing addresses and telephone numbers to be utilized by eligible employee or family members in seeking information or authorization; and

(3) An explanation that, if applicable, the insurance policy is a minimum benefit policy.

(b) This disclosure statement shall be presented in clear and understandable form and format and shall be separate from the basic policy or certificate or evidence of coverage provided to an eligible employee or family member.

(c) Before any insurer issues a basic policy pursuant to this article, it shall obtain from the eligible employer applying for such policy a signed written statement in which each eligible employee:

(1) Certifies as to eligibility for coverage under the basic policy; and

(2) Acknowledges the limited nature of the coverage provided under the basic policy.

(d) All marketing communication intended to be utilized in the marketing of a basic policy issued pursuant to this article shall be filed with and approved by the commissioner prior to use and shall contain the disclosures required by this section.

§33-16C-8. Certification by employer.

Every employer applying for insurance coverage pursuant to this article shall certify to the insurer, on a form prescribed by the insurance commissioner, that the employer has not had health insurance benefits for the twelve months preceding application.

§33-16C-9. Promulgation of rules.

The insurance commissioner shall promulgate rules and regulations, pursuant to chapter twenty-nine-a of this code, establishing procedures for implementing the provisions of this article.

§33-16C-10. Exemption from insurance premiums tax.

The premiums paid for insurance provided pursuant to this article shall be exempt from the premium tax required to be paid pursuant to sections fourteen and fourteen-a, article three of this chapter.

ARTICLE 16D. MARKETING AND RATE PRACTICES FOR SMALL EMPLOYER ACCIDENT AND SICKNESS INSURANCE POLICIES.

§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 insurer is in compliance with the provisions 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 insurer 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 insurer to small employers with similar case characteristics for health benefit plans within the same or similar coverage.

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

(d) "Class of business" means all or any distinct grouping of small employers as shown on the records of the small employer insurer.

(e) "Commissioner" means the insurance commissioner of West Virginia.

(f) "Department" means the department of insurance.

(g) "Duration rating" means the practice of rating a policy or a group of policies by the length of time they have been in force.

(h) "Health benefit plan" means any hospital or medical expense incurred policy; health, hospital or medical service corporation contract; plan provided by

a multiple-employer trust or a multiple-employer welfare arrangement; health maintenance organization contract offered by an employer; or any other policy or plan issued by an insurer which provides health related benefits to small employers: *Provided,* That for purposes of this article, a health benefit plan shall not include accident only, credit, dental, disability income insurance; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(i) "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.

(j) "Insurer" or "carrier" means any entity which holds a valid certificate of authority from the commissioner and which offers or sells health benefit plans to small employers situate in the state of West Virginia, regardless of where the policy or plan is drafted, issued or mailed, including, but not limited to, any insurance company authorized to transact accident and sickness insurance; a hospital service corporation, medical service corporation or health service corporation organized pursuant to article twenty-four of this chapter; a health care corporation organized pursuant to article twenty-five of this chapter; a health maintenance organization organized pursuant to article twenty-five-a of this chapter; or any multiple-employer trust or multiple-employer welfare arrangement.

(k) "Multiple employer trust" means an insured health benefit plan organized as a trust which offers benefits to small employers and is partially or fully insured by an insurer, which such underwriting insurer shall be deemed to be transacting insurance as defined in section four, article one of this chapter, and

is subject to this article regardless of where the policy or plan is delivered, issued for delivery, renewed or continued.

(l) "Multiple employer welfare arrangement" means an employee welfare benefit plan, or any other arrangement which is not fully insured and which is established or maintained for the purpose of offering or providing any insurance or other benefit to employees of two or more employers, and may include multiple employer trusts as defined in subsection (k) herein: *Provided,* That such term does not include any such plan or other arrangement which is established or maintained under or pursuant to one or more agreements found, under federal law, to be collective bargaining agreements, or by a rural electric cooperative, and is subject to this article regardless of where the policy or plan is delivered, issued for delivery, renewed or continued.

(m) "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 insurer to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

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

(o) "Small employer" means any person, firm, corporation, partnership or association actively engaged in business in the state of West Virginia for at least one year who, on at least fifty percent of its working days during the preceding year, employed no more than forty-nine or not less than two eligible employees: *Provided,* That companies which are affiliated companies or which are eligible to file a combined tax return for state tax purposes shall be considered one employer.

(p) "Small employer insurer" means any insurer which offers health benefit plans covering the

employees of a small employer situate within the state of West Virginia.

(q) "Tier rating" means the division of insureds to reflect risk and the subsequent selection by the insurer of only those groups which are financially attractive.

§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 two 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, chapter thirty-three of this code.

§33-16D-4. Discrimination in marketing prohibited; annual filing with commissioner; violations and penalties.

(a) All insurers 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) All insurers 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 ten thousand dollars. 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 benefits 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 twenty-five 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 subdivisions (1) or (2), subsection (a) of this section 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) A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business. A small employer carrier shall 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.

(d) To be eligible to make a rate increase request after the first day of July, one thousand nine hundred ninety-one, an insurer must have a minimum anticipated loss ratio of sixty-five percent.

(e) All insurers subject to this article, effective the first day of July, one thousand nine hundred ninety-three, shall be prohibited from distinguishing more than four classes of businesses within its small group insurance coverage.

(f) Prior to any increase of the anticipated loss ratio, the insurance commissioner must conduct a public hearing as required by section thirteen, article two of this chapter.

(g) If any health benefit plan is provided by an insurer through an association of small employers not in the business of selling insurance and with not less 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.

(a) Pursuant to chapter twenty-nine-a of this code, the insurance commissioner shall promulgate rules and regulations necessary to implement the provisions of this article.

(b) The rules and regulations promulgated by the commissioner shall include, but not be limited to, the following:

(1) Rules and regulations regarding the regulation of administrative costs incurred by the insurers;

(2) Rules and regulations regarding the commissioner's authority to increase the anticipated loss ratio and for the collection of data on which to base said increase, including, but not limited to, information obtained from the health care cost review authority and the national insurance commissioners association;

(3) Rules and regulations setting forth the proce-

dures for filing rate applications; and

(4) Rules and regulations eliminating tier and duration ratings of small group insurers which are used to create artificial rates or unfair trade practices.

§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 an insurer may refuse to renew a health benefit plan 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 less than the number or 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) A small employer insurer may cease to renew all plans under a class of business. Upon the small employer's election of nonrenewal, the insurer 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.

(c) An insurer which exercises its right to cease to renew all plans in a class of business shall not:

(1) 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

(2) Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business

unless the insurer 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.

§33-16D-8. Disclosure of rating practices and renewability provisions.

(a) Each small employer insurer 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 insurer'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;

(4) The provisions relating to renewability of coverage; and

(5) An explanation, if applicable, that the small employer is purchasing a minimum benefits plan.

(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.

§33-16D-9. Maintenance of records.

(a) Each small employer insurer 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 insurer shall file each first

day of March with the commissioner an actuarial certification that the insurer is in compliance with the provisions of this article and that the rating methods of the insurer are actuarially sound. A copy of such certification shall be retained by the insurer at its principal place of business.

(c) A small employer insurer 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 insurance commissioner may suspend all or part of the requirements of this article applicable to one or more health benefit plans for one or more rating periods upon a filing by the small employer insurer and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the insurer or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

§33-16D-11. Effective date.

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; pre-existing conditions; continuous coverage restrictions.

Health benefit plans and, to the extent permitted by ERISA, other benefit arrangements covering small employers shall be subject to the following provisions:

(a) Pre-existing conditions provisions shall 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 date of coverage.

(b) In determining whether a pre-existing 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.

(c) Subject to subsections (a) and (b) of this section, when a small group employer converts its health insurance plan from one health insurance plan to another health insurance plan or from one insurer to another insurer, all eligible employees who at the time of conversion are covered by the health benefit plan must 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 is treated under the current health benefit plan.

§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.

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS AND HEALTH SERVICE CORPORATIONS.

§33-24-4. Exemptions; applicability of insurance laws.

Every such corporation is hereby declared to be a scientific, nonprofit institution and as such exempt from the payment of all property and other taxes. Every such corporation, to the same extent such provisions are applicable to insurers transacting similar kinds of insurance and not inconsistent with the provisions of this article, shall be governed by and be subject to the provisions as hereinbelow indicated, of the following articles of this chapter: Article two (insurance commissioner), article four (general provisions), except that section sixteen of article four shall not be applicable thereto; article six, section thirty-four (fee for form and rate filing), article six-c (guaranteed loss ratio), article seven (assets and liabilities), article ten (rehabilitation and liquidation), article eleven (unfair practices and frauds), article twelve (agents, brokers and solicitors), section fourteen, article fifteen (individual policies), article fifteen-a (long-term care insurance), section three-a, article sixteen (mental illness), section three-a, article sixteen (mental illness), section three-c, article sixteen (group accident and sickness insurance), section three-d, article sixteen (medicare supplement), section three-f, article sixteen (treatment of temporomandibular joint disorder and craniomandibular disorder), article sixteen-c (small employer group policies), article sixteen-d (marketing and rate practices for small employers), article twenty-seven (insurance holding company systems), article twenty-eight (individual accident and sickness insurance minimum standards), article thirty-three (annual audited financial report), article thirty-four (administrative supervision), article thirty-four-a (standards and commissioner's authority for companies deemed to be in hazardous financial condition) and article thirty-five (criminal sanctions for failure to report impairment); and no other

provision of this chapter shall apply to such corporations unless specifically made applicable by the provisions of this article. If, however, any such corporation shall be converted into a corporation organized for a pecuniary profit, or if it shall transact business without having obtained a license as required by section five of this article, it shall thereupon forfeit its right to these exemptions.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-6. Supervision and regulation by insurance commissioner; exemption from insurance laws.

Corporations organized under this article shall be subject to supervision and regulation by the insurance commissioner. Any provisions of this chapter or of any other law to the contrary notwithstanding, such corporation shall not be subject to the insurance laws of this state now in force nor to any law hereafter enacted relating to insurance and corporations engaged in the business of insurance unless otherwise provided in this article or unless such other law specifically and in exact terms applies to such voluntary, nonprofit health care corporations as are organized under this article. Such corporations organized under this article, to the same extent such provisions are applicable to insurers transacting similar kinds of insurance and not inconsistent with the provisions of this article, shall be governed by and be subject to the provisions as hereinbelow indicated, of the following articles of this chapter: Article six-c (guaranteed loss ratio), article seven (assets and liabilities), article eight (investments), article ten (rehabilitation and liquidation), section fourteen, article fifteen (individual policies), article sixteen-c (small employer group policies), article sixteen-d (marketing and rate practices for small employers), article twenty-seven (insurance holding company systems), article thirty-four-a (standards and commissioner's authority for companies deemed to be in hazardous financial condition) and article thirty-five (criminal sanctions for failure to report impairment); and no other provision of this chapter shall apply to such corporations unless specif-

ically made applicable by the provisions of this article.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-24. Statutory construction and relationship to other laws.

(1) Except as otherwise provided in this article, provisions of the insurance law and provisions of hospital or medical service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this article. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this state except with respect to its health maintenance corporation activities authorized and regulated pursuant to this article.

(2) Factually accurate advertising or solicitation regarding the range of services provided, the premiums and copayments charged, the sites of services and hours of operation, and any other quantifiable, nonprofessional aspects of its operation by a health maintenance organization granted a certificate of authority, or its representative shall not be construed to violate any provision of law relating to solicitation or advertising by health professions: *Provided,* That nothing contained herein shall be construed as authorizing any solicitation or advertising which identifies or refers to any individual provider, or makes any qualitative judgment concerning any provider.

(3) Any health maintenance organization authorized under this article shall not be deemed to be practicing medicine and shall be exempt from the provision of chapter thirty of this code, relating to the practice of medicine.

(4) The provisions of article six-c (guaranteed loss ratio), article seven (assets and liabilities), article eight (investments), section fourteen, article fifteen (individual policies), section three-f, article sixteen (concerning treatment of temporomandibular disorder and

craniomandibular disorder), article sixteen-c (small employer group policies), article sixteen-d (marketing and rate practices for small employers), article twenty-seven (insurance holding company systems), article thirty-four-a (standards and commissioner's authority for companies deemed to be in hazardous financial condition) and article thirty-five (criminal sanctions for failure to report impairment) shall be applicable to any health maintenance organization granted a certificate of authority under this article.

(5) Any long-term care insurance policy delivered or issued for delivery in this state by a health maintenance organization shall comply with the provisions of article fifteen-a of this chapter.

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

Chairman Senate Committee

Chairman House Committee

Originated in the Senate.

To take effect July 1, 1991.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker House of Delegates

The within ~~is~~ approved this the 3rd day of April, 1991.

Governor

PRESENTED TO THE
GOVERNOR

Date _____

Time 10:35 am