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OFFICE WEST VIRGINIA
SECRETARY OF STATE

WEST VIRGINIA LEGISLATURE

Regular Session, 2005

ENROLLED

Committee Substitute for

SENATE BILL NO. 427

(By Senator Minard)

PASSED April 9, 2005

In Effect 90 days from **Passage**

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COMMITTEE SUBSTITUTE

FOR

Senate Bill No. 427

(SENATOR MINARD, *original sponsor*)

[Passed April 9, 2005; in effect ninety days from passage.]

AN ACT to repeal §33-25A-24a, §33-25A-24b, §33-25A-29 and §33-25A-30 of the Code of West Virginia, 1931, as amended; to amend and reenact §33-25A-3a, §33-25A-12, §33-25A-14, §33-25A-17, §33-25A-22, §33-25A-23 and §33-25A-24 of said code; to amend said code by adding thereto a new section, designated §33-25A-14a; and to amend and reenact §33-40-1, §33-40-2, §33-40-3, §33-40-6 and §33-40-7 of said code, all relating to health maintenance organizations; eliminating the requirement that a health maintenance organization be incorporated in this state in order to obtain a certificate of authority; eliminating the requirement of annual application for renewal of certificates of authority; increasing the time copies of grievances must be retained; permitting health status to be a basis for underwriting individual policies; changing the period in which examinations must be performed by the Commissioner from three to five years; increasing the filing fee for annual reports;

correcting a reference; clarifying scope of Commissioner's powers in performing examinations; clarifying that Insurance Fraud Prevention Act applies to health maintenance organizations; defining terms; and subjecting health maintenance organizations to risk-based capital requirements.

Be it enacted by the Legislature of West Virginia:

That §33-25A-24a, §33-25A-24b, §33-25A-29 and §33-25A-30 of the Code of West Virginia, 1931, as amended, be repealed; that §33-25A-3a, §33-25A-12, §33-25A-14, §33-25A-17, §33-25A-22, §33-25A-23 and §33-25A-24 of said code be amended and reenacted; that said code be amended by adding thereto a new section, designated §33-25A-14a; and that §33-40-1, §33-40-2, §33-40-3, §33-40-6 and §33-40-7 of said code be amended and reenacted, all to read as follows:

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-3a. Conditions precedent to issuance or maintenance of a certificate of authority; renewal of certificate of authority; effect of bankruptcy proceedings.

1 (a) As a condition precedent to the issuance or mainte-
2 nance of a certificate of authority, a health maintenance
3 organization shall file or have on file with the Commis-
4 sioner:

5 (1) An acknowledgment that a delinquency proceeding
6 pursuant to article ten of this chapter, or supervision by
7 the Commissioner pursuant to article thirty-four of this
8 chapter, constitute the exclusive methods for the liquida-
9 tion, rehabilitation, reorganization or conservation of a
10 health maintenance organization;

11 (2) A waiver of any right to file or be subject to a bank-
12 ruptcy proceeding;

13 (3) Within thirty days of any change in the membership
14 of the governing body of the organization or in the officers
15 or persons holding five percent or more of the common

16 stock of the organization, or as otherwise required by the
17 Commissioner:

18 (A) An amended list of the names, addresses and official
19 positions of each member of the governing body and a full
20 disclosure of any financial interest by a member of the
21 governing body or any provider or any organization or
22 corporation owned or controlled by that person and the
23 health maintenance organization and the extent and
24 nature of any contract or financial arrangements between
25 that person and the health maintenance organization; and

26 (B) A complete biographical statement on forms pre-
27 scribed by the Commissioner and an independent investi-
28 gation report on each person for whom a biographical
29 statement and independent investigation report have not
30 previously been submitted; and

31 (4) For health maintenance organizations that have been
32 operating in this state for at least three years, a copy of the
33 current quality assurance report submitted to the health
34 maintenance organization by a nationally recognized
35 accreditation and review organization approved by the
36 Commissioner, or in the case of the issuance of an initial
37 certificate of authority to a health maintenance organiza-
38 tion, a determination by the Commissioner as to the
39 feasibility of the health maintenance organization's
40 proposed quality assurance program: *Provided*, That if a
41 health maintenance organization files proof found in the
42 Commissioner's discretion to be sufficient to demonstrate
43 that the health maintenance organization has timely
44 applied for and reasonably pursued a review of its quality
45 assurance program, but a quality report has not been
46 issued by the accreditation and review organization, the
47 health maintenance organization shall be considered to
48 have complied with this subdivision.

49 (b) All certificates of authority issued to health mainte-
50 nance organizations expire at midnight on the thirty-first
51 day of May of each year. The Commissioner shall renew

52 annually the certificates of authority of all health mainte-
53 nance organizations that continue to meet all requirements
54 of this section and subsection (2), section four of this
55 article: *Provided*, That a health maintenance organization
56 shall not qualify for renewal of its certificate of authority
57 if the organization has no subscribers in this state within
58 twelve months after issuance of the certificate of author-
59 ity: *Provided, however*, That an organization not qualify-
60 ing for renewal may apply for a new certificate of author-
61 ity under section three of this article.

62 (c) The commencement of a bankruptcy proceeding
63 either by or against a health maintenance organization
64 shall, by operation of law;

65 Terminate the health maintenance organization's
66 certificate of authority; and

67 Vest in the Commissioner for the use and benefit of the
68 subscribers of the health maintenance organization the
69 title to any deposits of the health maintenance organiza-
70 tion held by the Commissioner: *Provided,* That if the
71 bankruptcy proceeding is initiated by a party other than
72 the health maintenance organization, the operation of this
73 subsection shall be stayed for a period of sixty days
74 following the date of commencement of the proceeding.

§33-25A-12. Grievance procedure.

1 (a) A health maintenance organization shall establish
2 and maintain a grievance procedure, which has been
3 approved by the Commissioner, to provide adequate and
4 reasonable procedures for the expeditious resolution of
5 written grievances initiated by enrollees concerning any
6 matter relating to any provisions of the organization's
7 health maintenance contracts, including, but not limited
8 to, claims regarding the scope of coverage for health care
9 services; denials, cancellations or nonrenewals of enrollee
10 coverage; observance of an enrollee's rights as a patient;
11 and the quality of the health care services rendered.

12 (b) A detailed description of the HMO's subscriber
13 grievance procedure shall be included in all group and
14 individual contracts as well as any certificate or member
15 handbook provided to subscribers. This procedure shall be
16 administered at no cost to the subscriber. An HMO
17 subscriber grievance procedure shall include the following:

18 (1) Both informal and formal steps shall be available to
19 resolve the grievance. A grievance is not considered
20 formal until a written grievance is executed by the sub-
21 scriber or completed on forms prescribed and received by
22 the HMO;

23 (2) Each HMO shall designate at least one grievance
24 coordinator who is responsible for the implementation of
25 the HMO's grievance procedure;

26 (3) Phone numbers shall be specified by the HMO for the
27 subscriber to call to present an informal grievance or to
28 contact the grievance coordinator. Each phone number
29 shall be toll free within the subscriber's geographic area
30 and provide reasonable access to the HMO without undue
31 delays. There must be an adequate number of phone lines
32 to handle incoming grievances;

33 (4) An address shall be included for written grievances;

34 (5) Each level of the grievance procedure shall have some
35 person with problem solving authority to participate in
36 each step of the grievance procedure;

37 (6) The HMO shall process the formal written subscriber
38 grievance through all phases of the grievance procedure in
39 a reasonable length of time not to exceed sixty days, unless
40 the subscriber and HMO mutually agree to extend the time
41 frame. If the complaint involves the collection of informa-
42 tion outside the service area, the HMO has thirty addi-
43 tional days to process the subscriber complaint through all
44 phases of the grievance procedure. The time limitations
45 prescribed in this subdivision requiring completion of the
46 grievance process within sixty days shall be tolled after

47 the HMO has notified the subscriber, in writing, that
48 additional information is required in order to properly
49 complete review of the grievance. Upon receipt by the
50 HMO of the additional information requested, the time for
51 completion of the grievance process set forth in this
52 subdivision shall resume;

53 (7) The subscriber grievance procedure shall state that
54 the subscriber has the right to appeal to the Commissioner.
55 There shall be the additional requirement that subscribers
56 under a group contract between the HMO and a depart-
57 ment or division of the state shall first appeal to the state
58 agency responsible for administering the relevant pro-
59 gram, and if either of the two parties are not satisfied with
60 the outcome of the appeal, they may then appeal to the
61 Commissioner. The HMO shall provide to the subscriber
62 written notice of the right to appeal upon completion of
63 the full grievance procedure and supply the Commissioner
64 with a copy of the final decision letter;

65 (8) The HMO shall have physician involvement in
66 reviewing medically related grievances. Physician in-
67 volvement in the grievance process should not be limited
68 to the subscriber's primary care physician, but may
69 include at least one other physician;

70 (9) The HMO shall offer to meet with the subscriber
71 during the formal grievance process. The location of the
72 meeting shall be at the administrative offices of the HMO
73 within the service area or at a location within the service
74 area which is convenient to the subscriber;

75 (10) The HMO may not establish time limits of less than
76 one year from the date of occurrence for the subscriber to
77 file a formal grievance;

78 (11) Each HMO shall maintain an accurate record of
79 each formal grievance. Each record shall include the
80 following: A complete description of the grievance, the
81 subscriber's name and address, the provider's name and

82 address and the HMO's name and address; a complete
83 description of the HMO's factual findings and conclusions
84 after completion of the full formal grievance procedure; a
85 complete description of the HMO's conclusions pertaining
86 to the grievance as well as the HMO's final disposition of
87 the grievance; and a statement as to which levels of the
88 grievance procedure the grievance has been processed and
89 how many more levels of the grievance procedure are
90 remaining before the grievance has been processed
91 through the HMO's entire grievance procedure.

92 (c) Copies of the grievances and the responses to the
93 grievances shall be available to the Commissioner and,
94 subject to state and federal privacy laws, to the public for
95 inspection for five years.

96 (d) Any subscriber grievance in which time is of the
97 essence shall be handled on an expedited basis, such that
98 a reasonable person would believe that a prevailing
99 subscriber would be able to realize the full benefit of a
100 decision in his or her favor.

101 (e) Each health maintenance organization shall submit
102 to the Commissioner an annual report in a form prescribed
103 by the Commissioner which describes the grievance
104 procedure and contains a compilation and analysis of the
105 grievances filed, their disposition, and their underlying
106 causes.

§33-25A-14. Prohibited advertising practices.

1 (a) No health maintenance organization, or representa-
2 tive of a health maintenance organization, may cause or
3 knowingly permit the use of advertising which is untrue or
4 misleading, solicitation which is untrue or misleading, or
5 any form of evidence of coverage which is deceptive. No
6 advertising may be used until it has been approved by the
7 Commissioner. Advertising which has not been disap-
8 proved by the Commissioner within sixty days of filing
9 shall be considered approved. For purposes of this article:

10 (1) A statement or item of information shall be consid-
11 ered to be untrue if it does not conform to fact in any
12 respect which is or may be significant to an enrollee of, or
13 person considering enrollment in, a health maintenance
14 organization;

15 (2) A statement or item of information shall be consid-
16 ered to be misleading, whether or not it may be literally
17 untrue if, in the total context in which the statement is
18 made or the item of information is communicated, the
19 statement or item of information may be reasonably
20 understood by a reasonable person, not possessing special
21 knowledge regarding health care coverage, as indicating
22 any benefit or advantage or the absence of any exclusion,
23 limitation, or disadvantage of possible significance to an
24 enrollee of, or person considering enrollment in, a health
25 maintenance organization, if the benefit or advantage or
26 absence of limitation, exclusion or disadvantage does not
27 in fact exist;

28 (3) An evidence of coverage shall be considered to be
29 deceptive if the evidence of coverage taken as a whole, and
30 with consideration given to typography and format, as
31 well as language, is such as to cause a reasonable person,
32 not possessing special knowledgeregarding health mainte-
33 nance organizations, and evidences of coverage therefor,
34 to expect benefits, services or other advantages which the
35 evidence of coverage does not provide or which the health
36 maintenance organization issuing the evidence of coverage
37 does not regularly make available for enrollees covered
38 under the evidence of coverage; and

39 (4) The Commissioner may propose rules for legislative
40 approval in accordance with article three, chapter twenty-
41 nine-a of this code to further define practices which are
42 untrue, misleading or deceptive.

43 (b) (1) No health maintenance organization may use in
44 its name, contracts, logo or literature any of the words
45 "insurance", "casualty", "surety", "mutual" or any other

46 words which are descriptive of the insurance, casualty or
47 surety business or deceptively similar to the name or
48 description of any insurance or surety corporation doing
49 business in this state: *Provided*, That when a health
50 maintenance organization has contracted with an insur-
51 ance company for any coverage permitted by this article,
52 it may so state; and

53 (2) Only a person that has been issued a certificate of
54 authority under this article may use the words "health
55 maintenance organization" or the initials "HMO" in its
56 name, contracts, logo or literature to imply, directly or
57 indirectly, that it is a health maintenance organization or
58 hold itself out to be a health maintenance organization.

59 (c) (1) No agent of a health maintenance organization or
60 person selling enrollments in a health maintenance
61 organization shall sell an enrollment in a health mainte-
62 nance organization unless the agent or person shall first
63 disclose in writing to the prospective purchaser the
64 following information using the following exact terms in
65 bold print: "Services offered", including any exclusions
66 or limitations; "full cost", including copayments; "facili-
67 ties available"; "transportation services"; "disenrollment
68 rate"; and "staff", including the names of all full-time
69 staff physicians, consulting specialists, hospitals and
70 pharmacies associated with the health maintenance
71 organization. In any home solicitation, any three-day
72 cooling-off period applicable to consumer transactions
73 generally applies in the same manner as consumer transac-
74 tions.

75 (2) The form disclosure statement shall not be used in
76 sales until it has been approved by the Commissioner or
77 submitted to the Commissioner for sixty days without
78 disapproval.

79 (d) No contract with an enrollee shall prohibit an
80 enrollee from canceling his or her enrollment at any time

81 for any reason except that the contract may require thirty
82 days' notice to the health maintenance organization.

83 (e) Any person who, in connection with an enrollment,
84 violates any provision of this section may be held liable for
85 an amount equivalent to one year's subscription rate, plus
86 costs and a reasonable attorney's fee.

§33-25A-14a. Other prohibited practices.

1 (a) No health maintenance organization may cancel or
2 fail to renew the coverage of an enrollee except for: (1)
3 Failure to pay the charge for health care coverage; (2)
4 termination of the health maintenance organization; (3)
5 termination of the group plan; (4) enrollee moving out of
6 the area served; (5) enrollee moving out of an eligible
7 group; or (6) other reasons established in rules promul-
8 gated by the Commissioner. No health maintenance
9 organization shall use any technique of rating or grouping
10 to cancel or fail to renew the coverage of an enrollee. An
11 enrollee shall be given thirty days' notice of any cancella-
12 tion or nonrenewal and the notice shall include the reasons
13 for the cancellation or nonrenewal: *Provided*, That each
14 enrollee moving out of an eligible group shall be granted
15 the opportunity to enroll in the health maintenance
16 organization on an individual basis. A health maintenance
17 organization may not disenroll an enrollee for nonpayment
18 of copayments unless the enrollee has failed to make
19 payment in at least three instances over any twelve-month
20 period: *Provided, however*, That the enrollee may not be
21 disenrolled if the disenrollment would constitute abandon-
22 ment of a patient. Any enrollee wrongfully disenrolled
23 shall be reenrolled.

24 (b) The providers of a health maintenance organization
25 who provide health care services and the health mainte-
26 nance organization shall not have recourse against en-
27 rollees for amounts above those specified in the evidence
28 of coverage as the periodic prepayment or copayment for
29 health care services.

30 (c) No health maintenance organization shall enroll more
31 than three hundred thousand persons in this state: *Pro-*
32 *vided,* That a health maintenance organization may
33 petition the Commissioner to exceed an enrollment of
34 three hundred thousand persons and, upon notice and
35 hearing, good cause being shown and a determination
36 made that an increase would be beneficial to the subscrib-
37 ers, creditors and stockholders of the organization or
38 would otherwise increase the availability of coverage to
39 consumers within the state, the Commissioner may, by
40 written order only, allow the petitioning organization to
41 exceed an enrollment of three hundred thousand persons.

42 (d) No health maintenance organization shall discrimi-
43 nate in enrollment policies or quality of services against
44 any person on the basis of race, sex, age, religion, place of
45 residence, source of payment or, with respect to enrollment
46 in group policies, health status: *Provided,* That differences
47 in rates based on valid actuarial distinctions, including
48 distinctions relating to age and sex, shall not be considered
49 discrimination in enrollment policies.

50 (e) Any person who, in connection with an enrollment,
51 violates any provision of this section may be held liable for
52 an amount equivalent to one year's subscription rate, plus
53 costs and a reasonable attorney's fee.

§33-25A-17. Examinations.

1 (a) The Commissioner may make an examination of the
2 affairs of any health maintenance organization and
3 providers with whom the organization has contracts,
4 agreements or other arrangements as often as he or she
5 considers it necessary for the protection of the interests of
6 the people of this state but not less frequently than once
7 every five years.

8 (b) The Commissioner may contract with the Department
9 of Health and Human Resources, any entity which has
10 been accredited by a nationally recognized accrediting

11 organization and has been approved by the Commissioner
12 to make examinations concerning the quality of health
13 care services of any health maintenance organization and
14 providers with whom the organization has contracts,
15 agreements or other arrangements, or any entity con-
16 tracted with by the Department of Health and Human
17 Resources, as often as it considers necessary for the
18 protection of the interests of the people of this state, but
19 not less frequently than once every three years: *Provided*,
20 That in making the examination, the Department of
21 Health and Human Resources or the accredited entity shall
22 use the services of persons or organizations with demon-
23 strable expertise in assessing quality of health care.

24 (c) Every health maintenance organization and affiliated
25 provider shall submit its books and records to the exami-
26 nations and in every way facilitate them. For the purpose
27 of examinations, the Commissioner and the Department of
28 Health and Human Resources have all powers necessary to
29 conduct the examinations, including, but not limited to,
30 the power to issue subpoenas, the power to administer
31 oaths to and examine the officers and agents of the health
32 maintenance organization and the principals of the
33 providers concerning their business.

34 (d) The health maintenance organization and any other
35 entity subject to examination pursuant to this article are
36 subject to the provisions of sections four, five, six, seven,
37 eight and nine, article two of this chapter in regard to the
38 expense and conduct of examinations.

39 (e) In lieu of the examination, the Commissioner may
40 accept the report of an examination made by other states.

41 (f) The expenses of an examination assessing quality of
42 health care under subsection (b) of this section and section
43 seventeen-a of this article shall be reimbursed pursuant to
44 subsection (n), section nine, article two of this chapter.

§33-25A-22. Fees.

1 Every health maintenance organization subject to this
2 article shall pay to the Commissioner the following fees:
3 For filing an application for a certificate of authority or
4 amendment to the application, two hundred dollars; for
5 each renewal of a certificate of authority, the annual fee as
6 provided in section thirteen, article three of this chapter;
7 for each form filing and for each rate filing, the fee, as
8 provided in section thirty-four, article six of this chapter;
9 and for filing each annual report, one hundred dollars.
10 Fees charged under this section shall be for the purposes
11 set forth in section thirteen, article three of this chapter.

§33-25A-23. Penalties and enforcement.

1 (1) The Commissioner may, in lieu of suspension or
2 revocation of a certificate of authority under section
3 eighteen of this article, levy an administrative penalty in
4 an amount not less than one hundred dollars nor more
5 than five thousand dollars, if reasonable notice in writing
6 is given of the intent to levy the penalty and the health
7 maintenance organization has a reasonable time within
8 which to remedy the defect in its operations which gave
9 rise to the penalty citation. The Commissioner may
10 augment this penalty by an amount equal to the sum that
11 he or she calculates to be the damages suffered by en-
12 rollees or other members of the public.

13 (2) Any person who violates any provision of this article
14 shall be guilty of a misdemeanor and, upon conviction
15 thereof, shall be fined not less than one thousand dollars
16 nor more than ten thousand dollars, or imprisoned in jail
17 not more than one year, or both fined and imprisoned.

18 (3) (a) If the Commissioner has cause to believe that any
19 violation of this article or rules promulgated pursuant to
20 this article has occurred or is threatened, prior to the levy
21 of a penalty or suspension or revocation of a certificate of
22 authority, the Commissioner shall give notice to the health

23 maintenance organization and to the representatives, or
24 other persons who appear to be involved in the suspected
25 violation, to arrange a conference with the alleged viola-
26 tors or their authorized representatives for the purpose of
27 attempting to ascertain the facts relating to the suspected
28 violation and, in the event it appears that any violation
29 has occurred or is threatened, to arrive at an adequate and
30 effective means of correcting or preventing the violation.

31 (b) Proceedings under this subsection shall not be
32 governed by any formal procedural requirements and may
33 be conducted in a manner the Commissioner determines
34 appropriate under the circumstances. Enrollees shall be
35 afforded notice by publication of proceedings under this
36 subsection and shall be afforded the opportunity to
37 intervene.

38 (4) (a) The Commissioner may issue an order directing a
39 health maintenance organization or a representative of a
40 health maintenance organization to cease and desist from
41 engaging in any act or practice in violation of the provi-
42 sions of this article or regulations promulgated pursuant
43 to this article.

44 (b) Within ten days after service of the order of cease and
45 desist, the respondent may request a hearing on the
46 question of whether acts or practices in violation of this
47 article have occurred. The hearings shall be conducted
48 pursuant to chapter twenty-nine-a of this code and
49 judicial review shall be available as provided by chapter
50 twenty-nine-a of this code.

51 (5) In the case of any violation of the provisions of this
52 article or rules promulgated pursuant to this article, if the
53 Commissioner elects not to issue a cease and desist order,
54 or in the event of noncompliance with a cease and desist
55 order issued pursuant to subsection (4) of this section, the
56 Commissioner may institute a proceeding to obtain
57 injunctive relief, or seek other appropriate relief, in the

58 circuit court of the county of the principal place of busi-
59 ness of the health maintenance organization.

60 (6) Any enrollee of or resident of the service area of the
61 health maintenance organization may bring an action to
62 enforce any provision, standard or rule enforceable by the
63 Commissioner. In the case of any successful action to
64 enforce this article, or accompanying standards or rules
65 the individual shall be awarded the costs of the action
66 together with a reasonable attorney's fee as determined by
67 the court.

§33-25A-24. Scope of provisions; applicability of other laws.

1 (a) Except as otherwise provided in this article, provi-
2 sions of the insurance laws and provisions of hospital or
3 medical service corporation laws are not applicable to any
4 health maintenance organization granted a certificate of
5 authority under this article. The provisions of this article
6 shall not apply to an insurer or hospital or medical service
7 corporation licensed and regulated pursuant to the insur-
8 ance laws or the hospital or medical service corporation
9 laws of this state except with respect to its health mainte-
10 nance corporation activities authorized and regulated
11 pursuant to this article. The provisions of this article may
12 not apply to an entity properly licensed by a reciprocal
13 state to provide health care services to employer groups,
14 where residents of West Virginia are members of an
15 employer group, and the employer group contract is
16 entered into in the reciprocal state. For purposes of this
17 subsection, a "reciprocal state" means a state which
18 physically borders West Virginia and which has subscriber
19 or enrollee hold harmless requirements substantially
20 similar to those set out in section seven-a of this article.

21 (b) Factually accurate advertising or solicitation regard-
22 ing the range of services provided, the premiums and
23 copayments charged, the sites of services and hours of
24 operation and any other quantifiable, nonprofessional
25 aspects of its operation by a health maintenance organiza-

26 tion granted a certificate of authority or its representative
27 may not be construed to violate any provision of law
28 relating to solicitation or advertising by health profes-
29 sions: *Provided*, That nothing contained in this subsection
30 shall be construed as authorizing any solicitation or
31 advertising which identifies or refers to any individual
32 provider or makes any qualitative judgment concerning
33 any provider.

34 (c) Any health maintenance organization authorized
35 under this article may not be considered to be practicing
36 medicine and is exempt from the provisions of chapter
37 thirty of this code relating to the practice of medicine.

38 (d) The following provisions of this chapter shall be
39 applicable to any health maintenance organization
40 granted a certificate of authority under this article or
41 which is otherwise subject to the provisions of this article:
42 The provisions of sections four, five, six, seven, eight, nine
43 and nine-a, article two (Insurance Commissioner); sections
44 fifteen and twenty, article four (general provisions);
45 section twenty, article five (borrowing by insurers); section
46 seventeen, article six (validity of noncomplying forms);
47 article six-c (guaranteed loss ratios as applied to individ-
48 ual sickness and accident insurance policies); article seven
49 (assets and liabilities); article eight (investments); article
50 eight-a (use of clearing corporations and federal reserve
51 book-entry system); article nine (administration of depos-
52 its); article ten (rehabilitation and liquidation); article
53 twelve (insurance producers and solicitors); section
54 fourteen, article fifteen (policies discriminating among
55 health care providers); section sixteen, article fifteen
56 (policies not to exclude insured's children from coverage;
57 required services; coordination with other insurance);
58 section eighteen, article fifteen (equal treatment of state
59 agency); section nineteen, article fifteen (coordination of
60 benefits with Medicaid); article fifteen-b (Uniform Health
61 Care Administration Act); section three, article sixteen
62 (required policy provisions); section three-f, article sixteen
63 (required policy provisions – treatment of temporo-

64 mandibular joint disorder and craniomandibular disorder);
65 section eleven, article sixteen (group policies not to
66 exclude insured's children from coverage; required ser-
67 vices; coordination with other insurance); section thirteen,
68 article sixteen (equal treatment of state agency); section
69 fourteen, article sixteen (coordination of benefits with
70 Medicaid); article sixteen-a (group health insurance
71 conversion); article sixteen-d (marketing and rate prac-
72 tices for small employer accident and sickness insurance
73 policies); article twenty-five-c (Health Maintenance
74 Organization Patient Bill of Rights); article twenty-five-f
75 (coverage for patient cost of clinical trials); article
76 twenty-seven (insurance holding company systems); article
77 thirty-three (annual audited financial report); article
78 thirty-four (administrative supervision); article
79 thirty-four-a (standards and Commissioner's authority for
80 companies considered to be in hazardous financial condi-
81 tion); article thirty-five (criminal sanctions for failure to
82 report impairment); article thirty-seven (managing general
83 agents); article thirty-nine (disclosure of material transac-
84 tions); article forty (risk-based capital for insurers); article
85 forty-one (Insurance Fraud Prevention Act); and article
86 forty-two (Women's Access to Health Care Act). In
87 circumstances where the code provisions made applicable
88 to health maintenance organizations by this subsection
89 refer to the "insurer", the "corporation" or words of
90 similar import, the language shall be construed to include
91 health maintenance organizations.

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

ARTICLE 40. RISK-BASED CAPITAL (RBC) FOR INSURERS.

§33-40-1. Definitions.

1 As used in this article, these terms have the following
2 meanings:

3 (a) "Adjusted RBC report" means an RBC report which
4 has been adjusted by the Commissioner in accordance with
5 subsection (e), section two of this article.

6 (b) "Corrective order" means an order issued by the
7 Commissioner specifying corrective actions which the
8 Commissioner has determined are required.

9 (c) "HMO" means the same as defined in subsection (11),
10 section two, article twenty-five-a of this chapter; as used
11 in sections one, three, four, five, seven, eight and twelve of
12 this article, the term "insurer" includes HMO.

13 (d) "Domestic insurer" means any insurance company,
14 farmers' mutual fire insurance company or HMO domi-
15 ciled in this state.

16 (e) "Foreign insurer" means any insurance company
17 which is licensed to do business in this state under article
18 three of this chapter but is not domiciled in this state or
19 any HMO that has been issued a certificate of authority
20 under article twenty-five-a of this chapter but that is not
21 domiciled in this state.

22 (f) "NAIC" means the National Association of Insurance
23 Commissioners.

24 (g) "Life and/or health insurer" means any insurance
25 company licensed under article three of this chapter or a
26 licensed property and casualty insurer writing only
27 accident and health insurance.

28 (h) "Property and casualty insurer" means any insurance
29 company licensed under article three of this chapter or any
30 farmers' mutual fire insurance company licensed under
31 article twenty-two of this chapter, but shall not include
32 monoline mortgage guaranty insurers, financial guaranty
33 insurers and title insurers.

34 (i) "Negative trend" means, with respect to a life and/or
35 health insurer, negative trend over a period of time, as

36 determined in accordance with the trend test calculation
37 included in the RBC instructions.

38 (j) "RBC instructions" means the RBC report, including
39 risk-based capital instructions adopted by the NAIC, as
40 the RBC instructions may be amended by the NAIC, from
41 time to time, in accordance with the procedures adopted
42 by the NAIC.

43 (k) "RBC level" means an insurer's or HMO's company
44 action level RBC, regulatory action level RBC, authorized
45 control level RBC, or mandatory control level RBC where:

46 (1) "Company action level RBC" means, with respect to
47 any insurer, the product of two and its authorized control
48 level RBC;

49 (2) "Regulatory action level RBC" means the product of
50 one and one-half and its authorized control level RBC;

51 (3) "Authorized control level RBC" means the number
52 determined under the risk-based capital formula in
53 accordance with the RBC instructions;

54 (4) "Mandatory control level RBC" means the product of
55 seven-tenths and the authorized control level RBC.

56 (l) "RBC plan" means a comprehensive financial plan
57 containing the elements specified in subsection (b), section
58 three of this article. If the Commissioner rejects the RBC
59 plan and it is revised by the insurer or HMO, with or
60 without the Commissioner's recommendation, the plan
61 shall be called the revised RBC plan.

62 (m) "RBC report" means the report required in section
63 two of this article.

64 (n) "Total adjusted capital" means the sum of:

65 (1) An insurer's or HMO's statutory capital and surplus
66 as determined in accordance with the statutory accounting
67 applicable to the financial statements required to be filed
68 under section fourteen, article four of this chapter; and

69 (2) Any other items required by the RBC instructions.

§33-40-2. RBC reports.

1 (a) Every domestic insurer shall, on or prior to each first
2 day of March (the "filing date"), prepare and submit to the
3 Commissioner a report of its RBC levels as of the end of
4 the calendar year just ended, in a form and containing the
5 information required by the RBC instructions. In addition,
6 every domestic insurer shall file its RBC report:

7 (1) With the NAIC in accordance with the RBC instruc-
8 tions; and

9 (2) With the Insurance Commissioner in any state in
10 which the insurer is authorized to do business, if the
11 Insurance Commissioner has notified the insurer of its
12 request in writing, in which case the insurer shall file its
13 RBC report not later than the later of:

14 (A) Fifteen days from the receipt of notice to file its RBC
15 report with that state; or

16 (B) The filing date.

17 (b) A life and health insurer's RBC shall be determined
18 in accordance with the formula set forth in the RBC
19 instructions. The formula shall take into account (and
20 may adjust for the covariance between):

21 (1) The risk with respect to the insurer's assets;

22 (2) The risk of adverse insurance experience with respect
23 to the insurer's liabilities and obligations;

24 (3) The interest rate risk with respect to the insurer's
25 business; and

26 (4) All other business risks and any other relevant risks
27 set forth in the RBC instructions determined in each case
28 by applying the factors in the manner set forth in the RBC
29 instructions.

30 (c) A property and casualty insurer's RBC and an HMO's
31 RBC shall be determined in accordance with the applica-
32 ble formula set forth in the RBC instructions. The formula
33 shall take into account (and may adjust for the covariance
34 between), determined in each case by applying the factors
35 in the manner set forth in the RBC instructions:

36 (1) Asset risk;

37 (2) Credit risk;

38 (3) Underwriting risk; and

39 (4) All other business risks and any other relevant risks
40 as are set forth in the RBC instructions.

41 (d) An excess of capital over the amount produced by the
42 risk-based capital requirements contained in this article
43 and the formulas, schedules and instructions referenced in
44 this article is desirable in the business of insurance.
45 Accordingly, insurers and HMOs should seek to maintain
46 capital above the RBC levels required by this article.
47 Additional capital is used and useful in the insurance
48 business and helps to secure insurers and HMOs against
49 various risks inherent in, or affecting, the business of
50 insurance and not accounted for or only partially mea-
51 sured by the risk-based capital requirements contained in
52 this article.

53 (e) If a domestic insurer files an RBC report which, in the
54 judgment of the Commissioner is inaccurate, then the
55 Commissioner shall adjust the RBC report to correct the
56 inaccuracy and shall notify the insurer of the adjustment.
57 The notice shall contain a statement of the reason for the
58 adjustment. An RBC report that is adjusted is referred to
59 as an "Adjusted RBC Report".

§33-40-3. Company action level event.

1 (a) "Company action level event" means any of the
2 following events:

3 (1) The filing of an RBC report by an insurer which
4 indicates that:

5 (A) The insurer's total adjusted capital is greater than or
6 equal to its regulatory action level RBC, but less than its
7 company action level RBC; or

8 (B) If a life and/or health insurer, the insurer has total
9 adjusted capital which is greater than or equal to its
10 company action level RBC, but less than the product of its
11 authorized control level RBC and two and one-half and
12 has a negative trend;

13 (2) The notification by the Commissioner to the insurer
14 of an adjusted RBC report that indicates an event in
15 subdivision (1) of this subsection, provided the insurer
16 does not challenge the adjusted RBC report under section
17 seven of this article; or

18 (3) If, pursuant to section seven of this article, an insurer
19 challenges an adjusted RBC report that indicates the event
20 in subdivision (1) of this subsection, the notification by the
21 Commissioner to the insurer that the Commissioner has,
22 after a hearing, rejected the insurer's challenge.

23 (b) In the event of a company action level event, the
24 insurer shall prepare and submit to the Commissioner an
25 RBC plan which shall:

26 (1) Identify the conditions which contribute to the
27 company action level event;

28 (2) Contain proposals of corrective actions which the
29 insurer intends to take and would be expected to result in
30 the elimination of the company action level event;

31 (3) Provide projections of the insurer's financial results
32 in the current year and at least the four succeeding years
33 or, in the case of an HMO, in the current year and at least
34 the two succeeding years, both in the absence of proposed
35 corrective actions and giving effect to the proposed
36 corrective actions, including projections of statutory

37 operating income, net income, capital and/or surplus. (The
38 projections for both new and renewal business may
39 include separate projections for each major line of busi-
40 ness and separately identify each significant income,
41 expense and benefit component);

42 (4) Identify the key assumptions impacting the insurer's
43 projections and the sensitivity of the projections to the
44 assumptions; and

45 (5) Identify the quality of, and problems associated with,
46 the insurer's business, including, but not limited to, its
47 assets, anticipated business growth and associated surplus
48 strain, extraordinary exposure to risk, mix of business and
49 use of reinsurance, if any, in each case.

50 (c) The RBC plan shall be submitted:

51 (1) Within forty-five days of the company action level
52 event; or

53 (2) If the insurer challenges an adjusted RBC report
54 pursuant to section seven of this article, within forty-five
55 days after notification to the insurer that the Commis-
56 sioner has, after a hearing, rejected the insurer's challenge.

57 (d) Within sixty days after the submission by an insurer
58 of an RBC plan to the Commissioner, the Commissioner
59 shall notify the insurer whether the RBC plan may be
60 implemented or is, in the judgment of the Commissioner,
61 unsatisfactory. If the Commissioner determines the RBC
62 plan is unsatisfactory, the notification to the insurer shall
63 set forth the reasons for the determination and may set
64 forth proposed revisions which will render the RBC plan
65 satisfactory in the judgment of the Commissioner. Upon
66 notification from the Commissioner, the insurer shall
67 prepare a revised RBC plan, which may incorporate by
68 reference any revisions proposed by the Commissioner,
69 and shall submit the revised RBC plan to the Commis-
70 sioner:

71 (1) Within forty-five days after the notification from the
72 Commissioner; or

73 (2) If the insurer challenges the notification from the
74 Commissioner under section seven of this article, within
75 forty-five days after a notification to the insurer that the
76 Commissioner has, after a hearing, rejected the insurer's
77 challenge.

78 (e) In the event of a notification by the Commissioner to
79 an insurer that the insurer's RBC plan or revised RBC plan
80 is unsatisfactory, the Commissioner may, at the Commis-
81 sioner's discretion, subject to the insurer's right to a
82 hearing under section seven of this article, specify in the
83 notification that the notification constitutes a regulatory
84 action level event.

85 (f) Every domestic insurer that files an RBC plan or
86 revised RBC plan with the Commissioner shall file a copy
87 of the RBC plan or revised RBC plan with the Insurance
88 Commissioner in any state in which the insurer is autho-
89 rized to do business if:

90 (1) The state has an RBC provision substantially similar
91 to subsection (a), section eight of this article; and

92 (2) The Insurance Commissioner of that state has noti-
93 fied the insurer of its request for the filing in writing, in
94 which case the insurer shall file a copy of the RBC plan or
95 revised RBC plan in that state no later than the later of:

96 (i) Fifteen days after the receipt of notice to file a copy
97 of its RBC plan or revised RBC plan with the state; or

98 (ii) The date on which the RBC plan or revised RBC plan
99 is filed under subsections (c) and (d) of this section.

§33-40-6. Mandatory control level event.

1 (a) "Mandatory control level event" means any of the
2 following events:

3 (1) The filing of an RBC report which indicates that the
4 insurer's or HMO's total adjusted capital is less than its
5 mandatory control level RBC;

6 (2) Notification by the Commissioner to the insurer or
7 HMO of an adjusted RBC report that indicates the event in
8 subdivision (1) of this subsection, provided the insurer or
9 HMO does not challenge the adjusted RBC report under
10 section seven of this article; or

11 (3) If, pursuant to section seven of this article, the
12 insurer or HMO challenges an adjusted RBC report that
13 indicates the event in subdivision (1) of this subsection,
14 notification by the Commissioner to the insurer or HMO
15 that the Commissioner has, after a hearing, rejected the
16 insurer's or HMO's challenge.

17 (b) In the event of a mandatory control level event:

18 (1) With respect to a life insurer, the Commissioner shall
19 take any actions that are necessary to place the insurer
20 under regulatory control under article ten of this chapter.
21 In that event, the mandatory control level event shall be
22 considered sufficient grounds for the Commissioner to take
23 action under said article, and the Commissioner has the
24 rights, powers and duties with respect to the insurer that
25 are set forth in said article. If the Commissioner takes
26 actions pursuant to an adjusted RBC report, the insurer is
27 entitled to the protections of said article pertaining to
28 summary proceedings. Notwithstanding any of the
29 provisions of this subdivision, the Commissioner may
30 forego action for up to ninety days after the mandatory
31 control level event if the Commissioner finds there is a
32 reasonable expectation that the mandatory control level
33 event may be eliminated within the ninety-day period.

34 (2) With respect to a property and casualty insurer, the
35 Commissioner shall take any actions that are necessary to
36 place the insurer under regulatory control under article
37 ten of this chapter or, in the case of an insurer which is

38 writing no business and which is running-off its existing
39 business, may allow the insurer to continue its run-off
40 under the supervision of the Commissioner. In either
41 event, the mandatory control level event shall be consid-
42 ered sufficient grounds for the Commissioner to take
43 action under said article and the Commissioner has the
44 rights, powers and duties with respect to the insurer that
45 are set forth in said article. If the Commissioner takes
46 actions pursuant to an adjusted RBC report, the insurer is
47 entitled to the protections of said article pertaining to
48 summary proceedings. Notwithstanding any of the
49 provisions of this subdivision, the Commissioner may
50 forego action for up to ninety days after the mandatory
51 control level event if the Commissioner finds there is a
52 reasonable expectation that the mandatory control level
53 event may be eliminated within the ninety-day period.

54 (3) With respect to HMO's, the Commissioner shall take
55 any actions that are necessary to place the HMO under
56 regulatory control in accordance with the provisions of
57 article ten and section nineteen, article twenty-five of this
58 chapter. In that event, the mandatory control level event
59 shall be considered sufficient grounds for the Commis-
60 sioner to take action under said section and the Commis-
61 sioner has the rights, powers and duties with respect to the
62 HMO as are set forth in said section. If the Commissioner
63 takes actions pursuant to an adjusted RBC report, the
64 HMO is entitled to the protections of said article pertain-
65 ing to summary proceedings. Notwithstanding any of the
66 provisions of this subdivision, the Commissioner may
67 forego action for up to ninety days after the mandatory
68 control level event if the Commissioner finds there is a
69 reasonable expectation that the mandatory control level
70 event may be eliminated within the ninety-day period.

§33-40-7. Hearings.

1 Insurers have the right to a confidential departmental
2 hearing, on the record, at which the insurer may challenge
3 any determination or action by the Commissioner made

4 pursuant to the provisions of this article. The insurer shall
5 notify the Commissioner of its request for a hearing within
6 ten days after receiving notification from the Commis-
7 sioner.

8 (a) Notification to an insurer by the Commissioner of an
9 adjusted RBC report; or

10 (b) Notification to an insurer by the Commissioner that:

11 (1) The insurer's RBC plan or revised RBC plan is
12 unsatisfactory; and

13 (2) The notification constitutes a regulatory action level
14 event with respect to the insurer; or

15 (c) Notification to any insurer by the Commissioner that
16 the insurer has failed to adhere to its RBC plan or revised
17 RBC plan and that the failure has a substantial adverse
18 effect on the ability of the insurer to eliminate the com-
19 pany action level event with respect to the insurer in
20 accordance with its RBC plan or revised RBC plan; or

21 (d) Notification to an insurer by the Commissioner of a
22 corrective order with respect to the insurer.

23 (e) Upon receipt of the insurer's request for a hearing,
24 the Commissioner shall set a date for the hearing, which
25 shall be no less than fifteen nor more than forty-five days
26 after the date of the insurer's request.

27 (f) To the extent that the provisions of this section
28 conflict with any other provisions applicable to HMO's,
29 the provisions of this section apply.

Enr. Com. Sub. for S. B. No. 427] 28

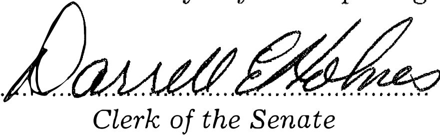
The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

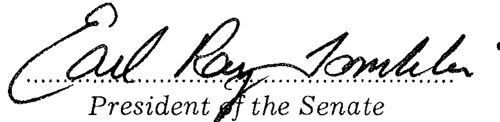
Originated in the Senate.

In effect ninety days from passage.

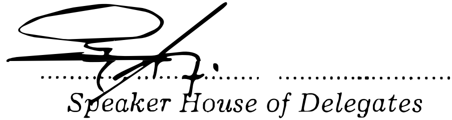


Clerk of the Senate

Clerk of the House of Delegates



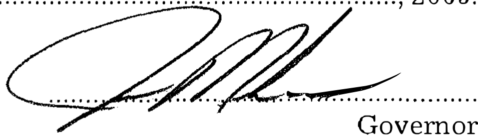
President of the Senate



Speaker House of Delegates

The within is approved this the 2nd

Day of May, 2005.



Governor

® GCIU 326-C

PRESENTED TO THE
GOVERNOR

APR 29 2005

Time 9:30 am