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That §33-25A-24a, §33-25A-24b, §33-25A-29 and §33-25A-30 of the Code of West Virginia, 1931, as amended, be repealed; that §33-25A-3a, §33-25A-12, §33-25A-14, §33-25A-17, §33-25A-22, §33-25A-23 and §33-25A-24 of said code be amended and reenacted; that said code be amended by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 maintenance of a certificate of authority, a health maintenance organization shall file or have on file with the Commissioner:

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

11 (2) A waiver of any right to file or be subject to a bankruptcy proceeding;

13 (3) Within thirty days of any change in the membership of the governing body of the organization or in the officers or persons holding five percent or more of the common
(A) An amended list of the names, addresses and official positions of each member of the governing body and a full disclosure of any financial interest by a member of the governing body or any provider or any organization or corporation owned or controlled by that person and the health maintenance organization and the extent and nature of any contract or financial arrangements between that person and the health maintenance organization; and

(B) A complete biographical statement on forms prescribed by the Commissioner and an independent investigation report on each person for whom a biographical statement and independent investigation report have not previously been submitted; and

(4) For health maintenance organizations that have been operating in this state for at least three years, a copy of the current quality assurance report submitted to the health maintenance organization by a nationally recognized accreditation and review organization approved by the Commissioner, or in the case of the issuance of an initial certificate of authority to a health maintenance organization, a determination by the Commissioner as to the feasibility of the health maintenance organization’s proposed quality assurance program: Provided, That if a health maintenance organization files proof found in the Commissioner’s discretion to be sufficient to demonstrate that the health maintenance organization has timely applied for and reasonably pursued a review of its quality assurance program, but a quality report has not been issued by the accreditation and review organization, the health maintenance organization shall be considered to have complied with this subdivision.

(b) All certificates of authority issued to health maintenance organizations expire at midnight on the thirty-first day of May of each year. The Commissioner shall renew
Enr. Com. Sub. for S. B. No. 427] 4

annually the certificates of authority of all health maintenance organizations that continue to meet all requirements of this section and subsection (2), section four of this article: Provided, That a health maintenance organization shall not qualify for renewal of its certificate of authority if the organization has no subscribers in this state within twelve months after issuance of the certificate of authority: Provided, however, That an organization not qualifying for renewal may apply for a new certificate of authority under section three of this article.

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

Terminate the health maintenance organization’s certificate of authority; and

Vest in the Commissioner for the use and benefit of the subscribers of the health maintenance organization the title to any deposits of the health maintenance organization held by the Commissioner: Provided, That if the bankruptcy proceeding is initiated by a party other than the health maintenance organization, the operation of this subsection shall be stayed for a period of sixty days following the date of commencement of the proceeding.


(a) A health maintenance organization shall establish and maintain a grievance procedure, which has been approved by the Commissioner, to provide adequate and reasonable procedures for the expeditious resolution of written grievances initiated by enrollees concerning any matter relating to any provisions of the organization’s health maintenance contracts, including, but not limited to, claims regarding the scope of coverage for health care services; denials, cancellations or nonrenewals of enrollee coverage; observance of an enrollee’s rights as a patient; and the quality of the health care services rendered.
(b) A detailed description of the HMO's subscriber grievance procedure shall be included in all group and individual contracts as well as any certificate or member handbook provided to subscribers. This procedure shall be administered at no cost to the subscriber. An HMO subscriber grievance procedure shall include the following:

(1) Both informal and formal steps shall be available to resolve the grievance. A grievance is not considered formal until a written grievance is executed by the subscriber or completed on forms prescribed and received by the HMO;

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

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

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

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

(6) The HMO shall process the formal written subscriber grievance through all phases of the grievance procedure in a reasonable length of time not to exceed sixty days, unless the subscriber and HMO mutually agree to extend the time frame. If the complaint involves the collection of information outside the service area, the HMO has thirty additional days to process the subscriber complaint through all phases of the grievance procedure. The time limitations prescribed in this subdivision requiring completion of the grievance process within sixty days shall be tolled after
the HMO has notified the subscriber, in writing, that additional information is required in order to properly complete review of the grievance. Upon receipt by the HMO of the additional information requested, the time for completion of the grievance process set forth in this subdivision shall resume;

(7) The subscriber grievance procedure shall state that the subscriber has the right to appeal to the Commissioner. There shall be the additional requirement that subscribers under a group contract between the HMO and a department or division of the state shall first appeal to the state agency responsible for administering the relevant program, and if either of the two parties are not satisfied with the outcome of the appeal, they may then appeal to the Commissioner. The HMO shall provide to the subscriber written notice of the right to appeal upon completion of the full grievance procedure and supply the Commissioner with a copy of the final decision letter;

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

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

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

(11) Each HMO shall maintain an accurate record of each formal grievance. Each record shall include the following: A complete description of the grievance, the subscriber's name and address, the provider's name and
address and the HMO's name and address; a complete
description of the HMO's factual findings and conclusions
after completion of the full formal grievance procedure; a
complete description of the HMO's conclusions pertaining
to the grievance as well as the HMO's final disposition of
the grievance; and a statement as to which levels of the
grievance procedure the grievance has been processed and
how many more levels of the grievance procedure are
remaining before the grievance has been processed
through the HMO's entire grievance procedure.

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

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

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


(a) No health maintenance organization, or representa-
tive of a health maintenance organization, may cause or
knowingly permit the use of advertising which is untrue or
misleading, solicitation which is untrue or misleading, or
any form of evidence of coverage which is deceptive. No
advertising may be used until it has been approved by the
Commissioner. Advertising which has not been disap-
proved by the Commissioner within sixty days of filing
shall be considered approved. For purposes of this article:
(1) A statement or item of information shall be considered to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health maintenance organization;

(2) A statement or item of information shall be considered to be misleading, whether or not it may be literally untrue if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health maintenance organization, if the benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist;

(3) An evidence of coverage shall be considered to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, is such as to cause a reasonable person, not possessing special knowledge regarding health maintenance organizations, and evidences of coverage therefor, to expect benefits, services or other advantages which the evidence of coverage does not provide or which the health maintenance organization issuing the evidence of coverage does not regularly make available for enrollees covered under the evidence of coverage; and

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

(b) (1) No health maintenance organization may use in its name, contracts, logo or literature any of the words “insurance”, “casualty”, “surety”, “mutual” or any other
words which are descriptive of the insurance, casualty or
surety business or deceptively similar to the name or
description of any insurance or surety corporation doing
business in this state: Provided, That when a health
maintenance organization has contracted with an insur-
ance company for any coverage permitted by this article,
it may so state; and

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

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

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

(d) No contract with an enrollee shall prohibit an
enrollee from canceling his or her enrollment at any time
for any reason except that the contract may require thirty
days' notice to the health maintenance organization.

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

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

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

(b) The providers of a health maintenance organization
who provide health care services and the health mainte-
nance organization shall not have recourse against en-
rollees for amounts above those specified in the evidence
of coverage as the periodic prepayment or copayment for
health care services.
(c) No health maintenance organization shall enroll more than three hundred thousand persons in this state: Provided, That a health maintenance organization may petition the Commissioner to exceed an enrollment of three hundred thousand persons and, upon notice and hearing, good cause being shown and a determination made that an increase would be beneficial to the subscribers, creditors and stockholders of the organization or would otherwise increase the availability of coverage to consumers within the state, the Commissioner may, by written order only, allow the petitioning organization to exceed an enrollment of three hundred thousand persons.

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

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

§33-25A-17. Examinations.

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

(b) The Commissioner may contract with the Department of Health and Human Resources, any entity which has been accredited by a nationally recognized accrediting
organization and has been approved by the Commissioner to make examinations concerning the quality of health care services of any health maintenance organization and providers with whom the organization has contracts, agreements or other arrangements, or any entity contracted with by the Department of Health and Human Resources, as often as it considers necessary for the protection of the interests of the people of this state, but not less frequently than once every three years: Provided, that in making the examination, the Department of Health and Human Resources or the accredited entity shall use the services of persons or organizations with demonstrable expertise in assessing quality of health care.

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

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

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

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

Every health maintenance organization subject to this article shall pay to the Commissioner the following fees:

For filing an application for a certificate of authority or amendment to the application, two hundred dollars; for each renewal of a certificate of authority, the annual fee as provided in section thirteen, article three of this chapter; for each form filing and for each rate filing, the fee, as provided in section thirty-four, article six of this chapter; and for filing each annual report, one hundred dollars.

Fees charged under this section shall be for the purposes set forth in section thirteen, article three of this chapter.

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

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

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

(3) (a) If the Commissioner has cause to believe that any violation of this article or rules promulgated pursuant to this article has occurred or is threatened, prior to the levy of a penalty or suspension or revocation of a certificate of authority, the Commissioner shall give notice to the health
maintenance organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.

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

(4) (a) The Commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this article or regulations promulgated pursuant to this article.

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

(5) In the case of any violation of the provisions of this article or rules promulgated pursuant to this article, if the Commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (4) of this section, the Commissioner may institute a proceeding to obtain injunctive relief, or seek other appropriate relief, in the
circuit court of the county of the principal place of business of the health maintenance organization.

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


(a) Except as otherwise provided in this article, provisions of the insurance laws and provisions of hospital or medical service corporation laws are not applicable to any health maintenance organization granted a certificate of authority under this article. The provisions of this article 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. The provisions of this article may not apply to an entity properly licensed by a reciprocal state to provide health care services to employer groups, where residents of West Virginia are members of an employer group, and the employer group contract is entered into in the reciprocal state. For purposes of this subsection, a “reciprocal state” means a state which physically borders West Virginia and which has subscriber or enrollee hold harmless requirements substantially similar to those set out in section seven-a of this article.

(b) Factly 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 organiza-
tion granted a certificate of authority or its representative
may not be construed to violate any provision of law
relating to solicitation or advertising by health profes-
sions: Provided, That nothing contained in this subsection
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.

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

(d) The following provisions of this chapter shall be
applicable to any health maintenance organization
granted a certificate of authority under this article or
which is otherwise subject to the provisions of this article:
The provisions of sections four, five, six, seven, eight, nine
and nine-a, article two (Insurance Commissioner); sections
fifteen and twenty, article four (general provisions);
section twenty, article five (borrowing by insurers); section
seventeen, article six (validity of noncomplying forms);
article six-c (guaranteed loss ratios as applied to individ-
ual sickness and accident insurance policies); article seven
(assets and liabilities); article eight (investments); article
eight-a (use of clearing corporations and federal reserve
book-entry system); article nine (administration of depos-
its); article ten (rehabilitation and liquidation); article
twelve (insurance producers and solicitors); section
fourteen, article fifteen (policies discriminating among
health care providers); section sixteen, article fifteen
(policies not to exclude insured's children from coverage;
required services; coordination with other insurance);
section eighteen, article fifteen (equal treatment of state
agency); section nineteen, article fifteen (coordination of
benefits with Medicaid); article fifteen-b (Uniform Health
Care Administration Act); section three, article sixteen
(required policy provisions); section three-f, article sixteen
(required policy provisions - treatment of temporo-
mandibular joint disorder and craniomandibular disorder);
section eleven, article sixteen (group policies not to
exclude insured's children from coverage; required ser-

vice; coordination with other insurance); section thirteen,
article sixteen (equal treatment of state agency); section
fourteen, article sixteen (coordination of benefits with
Medicaid); article sixteen-a (group health insurance
conversion); article sixteen-d (marketing and rate prac-
tices for small employer accident and sickness insurance
policies); article twenty-five-c (Health Maintenance
Organization Patient Bill of Rights); article twenty-five-f
(coverage for patient cost of clinical trials); article
twenty-seven (insurance holding company systems); article
thirty-three (annual audited financial report); article
thirty-four (administrative supervision); article
thirty-four-a (standards and Commissioner's authority for
companies considered to be in hazardous financial condi-
tion); article thirty-five (criminal sanctions for failure to
report impairment); article thirty-seven (managing general
agents); article thirty-nine (disclosure of material transac-
tions); article forty (risk-based capital for insurers); article
forty-one (Insurance Fraud Prevention Act); and article
forty-two (Women's Access to Health Care Act). In

circumstances where the code provisions made applicable
to health maintenance organizations by this subsection
refer to the "insurer", the "corporation" or words of
similar import, the language shall be construed to include
health maintenance organizations.

(e) 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.

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

§33-40-1. Definitions.

As used in this article, these terms have the following
meanings:
(a) "Adjusted RBC report" means an RBC report which has been adjusted by the Commissioner in accordance with subsection (e), section two of this article.

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

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

(d) "Domestic insurer" means any insurance company, farmers' mutual fire insurance company or HMO domiciled in this state.

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

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

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

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

(i) "Negative trend" means, with respect to a life and/or health insurer, negative trend over a period of time, as
determined in accordance with the trend test calculation included in the RBC instructions.

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

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

1. "Company action level RBC" means, with respect to any insurer, the product of two and its authorized control level RBC;
2. "Regulatory action level RBC" means the product of one and one-half and its authorized control level RBC;
3. "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;
4. "Mandatory control level RBC" means the product of seven-tenths and the authorized control level RBC.

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

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

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

1. An insurer's or HMO's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the financial statements required to be filed under section fourteen, article four of this chapter; and
(2) Any other items required by the RBC instructions.

§33-40-2. RBC reports.

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

(1) With the NAIC in accordance with the RBC instructions; and

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

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

(B) The filing date.

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

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

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

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

(4) All other business risks and any other relevant risks set forth in the RBC instructions determined in each case by applying the factors in the manner set forth in the RBC instructions.
(c) A property and casualty insurer’s RBC and an HMO’s RBC shall be determined in accordance with the applicable formula set forth in the RBC instructions. The formula shall take into account (and may adjust for the covariance between), determined in each case by applying the factors in the manner set forth in the RBC instructions:

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

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

(d) An excess of capital over the amount produced by the risk-based capital requirements contained in this article and the formulas, schedules and instructions referenced in this article is desirable in the business of insurance. Accordingly, insurers and HMOs should seek to maintain capital above the RBC levels required by this article. Additional capital is used and useful in the insurance business and helps to secure insurers and HMOs against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this article.

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

§33-40-3. Company action level event.

(a) “Company action level event” means any of the following events:
(1) The filing of an RBC report by an insurer which indicates that:

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

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

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

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

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

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

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

(3) Provide projections of the insurer’s financial results in the current year and at least the four succeeding years or, in the case of an HMO, in the current year and at least the two succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory
operating income, net income, capital and/or surplus. (The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense and benefit component);

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

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

(c) The RBC plan shall be submitted:

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

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

(d) Within sixty days after the submission by an insurer of an RBC plan to the Commissioner, the Commissioner shall notify the insurer whether the RBC plan may be implemented or is, in the judgment of the Commissioner, unsatisfactory. If the Commissioner determines the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination and may set forth proposed revisions which will render the RBC plan satisfactory in the judgment of the Commissioner. Upon notification from the Commissioner, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the revised RBC plan to the Commissioner:
(1) Within forty-five days after the notification from the Commissioner; or

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

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

(f) Every domestic insurer that files an RBC plan or revised RBC plan with the Commissioner shall file a copy of the RBC plan or revised RBC plan with the Insurance Commissioner in any state in which the insurer is authorized to do business if:

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

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

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

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

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

(a) "Mandatory control level event" means any of the following events:
(1) The filing of an RBC report which indicates that the insurer’s or HMO’s total adjusted capital is less than its mandatory control level RBC;

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

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

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

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

(2) With respect to a property and casualty insurer, the Commissioner shall take any actions that are necessary to place the insurer under regulatory control under article ten of this chapter or, in the case of an insurer which is
writing no business and which is running-off its existing business, may allow the insurer to continue its run-off under the supervision of the Commissioner. In either event, the mandatory control level event shall be considered sufficient grounds for the Commissioner to take action under said article and the Commissioner has the rights, powers and duties with respect to the insurer that are set forth in said article. If the Commissioner takes actions pursuant to an adjusted RBC report, the insurer is entitled to the protections of said article pertaining to summary proceedings. Notwithstanding any of the provisions of this subdivision, the Commissioner may forego action for up to ninety days after the mandatory control level event if the Commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.

(3) With respect to HMO's, the Commissioner shall take any actions that are necessary to place the HMO under regulatory control in accordance with the provisions of article ten and section nineteen, article twenty-five of this chapter. In that event, the mandatory control level event shall be considered sufficient grounds for the Commissioner to take action under said section and the Commissioner has the rights, powers and duties with respect to the HMO as are set forth in said section. If the Commissioner takes actions pursuant to an adjusted RBC report, the HMO is entitled to the protections of said article pertaining to summary proceedings. Notwithstanding any of the provisions of this subdivision, the Commissioner may forego action for up to ninety days after the mandatory control level event if the Commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.


Insurers have the right to a confidential departmental hearing, on the record, at which the insurer may challenge any determination or action by the Commissioner made
pursuant to the provisions of this article. The insurer shall notify the Commissioner of its request for a hearing within ten days after receiving notification from the Commissioner.

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

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

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

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

(c) Notification to any insurer by the Commissioner that the insurer has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its RBC plan or revised RBC plan; or

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

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

(f) To the extent that the provisions of this section conflict with any other provisions applicable to HMO's, the provisions of this section apply.
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 Day of , 2005.

Governor