WEST VIRGINIA LEGISLATURE

REGULAR SESSION, 1997

ENROLLED

HOUSE BILL No. 2667

(By Delegate Mr. Speaker, Mr. Kiss and Ashley [By Request of the Executive])

Passed April 12, 1997

In Effect From Passage

ENROLLED

COMMITTEE SUBSTITUTE

FOR

H. B. 2667

(By Mr. Speaker, Mr. Kiss, and Delegate Ashley)
[By Request of the Executive]

[Passed April 12, 1997; in effect from passage.]

AN ACT to repeal section fifteen, article fifteen, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended; to repeal article sixteen-c of said chapter; to amend and reenact sections two and twenty, article fifteen of said chapter; to further amend said article by adding thereto eight new sections, designated sections two-a, two-b, two-c, two-d, two-e, two-f, two-g and four-e; to amend article sixteen of said chapter by adding thereto seven new sections, designated sections one-a, three-j, three-k, three-l, three-m, three-n and seventeen; to amend and reenact sections three-a and fifteen of said article; to amend and reenact sections two, four, five, seven, eight, ten, eleven and twelve, article sixteen-d of said chapter; to further amend said article by adding thereto one new section, designated section fifteen; to amend and reenact section twenty-four, article twenty-three of said chapter; to amend and reenact section four, article twenty-four of said chapter; to amend and reenact section six, article twenty-five of said chapter; and to amend and reenact section twenty-four, article twenty-five-a of said chapter, all relating to the availability and continuity of health insurance coverage for individuals, small groups and large groups in accordance with the health insurance

portability and accountability act of 1996, commonly known as the Kennedy-Kassebaum bill, and related federal mandates; specifying exceptions under which an insurer may deny coverage under individual accident and sickness insurance policies; authority for the commissioner to study alternatives to guaranteed issue of individual accident and sickness insurance policies; exceptions under which an insurer may nonrenew or discontinue individual accident and sickness insurance coverage; providing for discontinuation or modification of individual accident and sickness insurance coverage; limitation of preexisting condition exclusions; establishment of individual medical savings accounts; guaranteed renewability of health insurance coverage; guaranteed issuance of health insurance coverage for eligible individuals and small groups and related premium calculation; preexisting health conditions; premium rates; credit for prior coverage; parity of physical and mental health insurance coverage for large groups; minimum hospital stays for mothers and newborns; the applicability of these provisions to entities providing accident and sickness insurance coverage; and a study of the feasibility and advisability of extending continuation coverage to groups of fewer than twenty employees.

Be it enacted by the Legislature of West Virginia:

That section fifteen, article fifteen, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be repealed; that article sixteen-c of said chapter be repealed; that sections two and twenty, article fifteen of said chapter be amended and reenacted; that said article be further amended by adding thereto eight new sections, designated sections two-a, two-b, two-c, two-d, two-e, two-f, two-g and four-e; that article sixteen of said chapter be amended by adding thereto seven new sections, designated sections one-a, three-j, three-k, three-l, three-m, three-n and seventeen; that sections three-a and fifteen of said article be amended and reenacted; that sections two, four, five, seven, eight, ten, eleven and twelve, article sixteen-d of said chapter be amended and reenacted; that said article be further amended by adding thereto one new section, designated section fifteen; that section twenty-four, article twenty-three of said chapter be amended and reenacted; that section four, article twenty-four of said chapter be amended and

reenacted; that section six, article twenty-five of said chapter be amended and reenacted; and that section twenty-four, article twenty-five-a of said chapter be amended and reenacted, all to read as follows:

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-2. Scope and format of policy.

No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

(a) The entire money and other considerations therefor are expressed therein; and

(b) The time at which the insurance takes effect and terminates is expressed therein; and

(c) It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed nineteen years and any other person dependent upon the policyholder; and

(d) The policy is guaranteed to be renewable at the option of the insured except as provided in section two-d of this article; and

(e) The style, arrangement and over-all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lowercase unspaced alphabet length not less than one hundred and twenty-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions), the policy shall clearly indicate on the first page the conditions of renewability; and

(f) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in sections four and five of this article, are printed, at the insurer's option, either included with the benefit provisions to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and Reductions": *Provided,* That if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; and

(g) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first part thereof; and

(h) It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner; and

(i) Effective the first day of July, one thousand nine hundred ninety-seven, the insurer offers and accepts for enrollment pursuant to section two-b of this article every eligible individual who applies for coverage within sixty-three days after termination of the individual's prior creditable coverage.

§33-15-2a. Definitions.

For purposes of this section and sections two-b, two-c, two-d, two-e, two-f, two-g and four-e:

(a) "Accident and sickness insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy of certificate, hospital or medical service plan contract, or health maintenance organization contract offered by an insurer, but does not include short-term limited duration insurance.

(b) "Bona fide association" means an association which has been actively in existence for at least five years; has been formed and maintained in good faith for purposes other than obtaining insurance; does not condition membership in the association on any health status-related factor relating to an individual; makes accident and sickness insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member; does not make accident and sickness insurance coverage offered through the association available other than in connection with a member of the association; and meets any additional requirements as may be set forth in this chapter or by rule.

(c) "COBRA continuation provision" means any of the following:

(1) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines;

(2) Part 6 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, other than Section 609 of such act; or

(3) Title XXII of the Public Health Service Act.

(d) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(1) A group health plan;

(2) Accident and sickness insurance coverage;

(3) Part A or part B of Title XVIII of the Social Security Act;

(4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

(5) Chapter 55 of Title 10 of the United States Code;

(6) A medical care program of the Indian Health Service or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under Chapter 89 of Title 5 of the United States Code;

(9) A public health plan (as defined in federal regulations); or

(10) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

The term "creditable coverage" does not include those benefits set forth in section two-g of this article.

(e) "Eligible individual" means an individual:

(1) For whom, as of the date on which the individual seeks coverage, the aggregate period of creditable coverage is eighteen months or more and whose most recent prior creditable coverage was under a group health plan, governmental plan (as defined in section 3(32) of the Employee Retirement Income Security Act of 1974), church plan (as defined in section 3(33) of the Employee Retirement Income Security Act of 1974), or accident and sickness insurance coverage offered in connection with any such plan;

(2) Who is not eligible for coverage under a group health plan, part A or part B of Title XVIII of the Social Security Act, or state plan under Title XIX of such act (or any successor program), and does not have other accident and sickness insurance coverage;

(3) With respect to whom the most recent prior creditable coverage was not terminated as a result of fraud, intentional misrepresentation of material fact under the terms of the coverage, or nonpayment of premium;

(4) Who did not turn down an offer of continuation of coverage under a COBRA continuation provision or under a similar state program if it was offered; and

(5) Who, if the individual elected such continuation coverage, has exhausted that coverage under the COBRA continuation provision or similar state program.

(f) "Group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care to employees and their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement or otherwise.

(g) "Health status-related factor" means an individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, and evidence of insurability (including conditions arising out of acts of domestic violence) or disability.

(h) "Higher-level coverage" means a policy form for which the actuarial value of the benefits under the coverage is at least fifteen percent greater than the actuarial value of lower-level coverage offered by the insurer in this state, and the actuarial value of the benefits under the coverage is at least one hundred percent but not greater than one hundred twenty percent of a weighted average.

(i) "Individual market" means the market for accident and sickness insurance coverage offered to individuals other than in connection with a group health plan.

(j) "Insurer" means an entity licensed by the commissioner to transact accident and sickness insurance in this state and subject to this chapter, but does not include a group health plan or short term limited duration insurance.

(k) "Lower-level coverage" means a policy form for which the actuarial value of the benefits under the coverage is at least eighty-five percent but not greater than one hundred percent of a weighted average.

(l) "Medical care" means amounts paid for, or paid for insurance covering, the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, including the amounts paid for transportation primarily for and essential to such care.

(m) "Network plan" means accident and sickness insurance coverage of an insurer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a definite set of providers under contract with the insurer.

(n) "Preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

(o) "Weighted average" means the average actuarial value of the benefits provided by all the accident and sickness insurance coverage issued (as elected by the insurer) either by that insurer or by all insurers in this state in the individual accident and sickness market during the previous year (not including coverage issued under this section), weighted by enrollment for the different coverage.

§33-15-2b. Guaranteed issue; limitation of coverage; election; denial of coverage; network plans.

(a) Each insurer that offers accident and sickness insurance coverage in the individual market in this state may not, with respect to an eligible individual desiring to enroll in individual accident and sickness insurance coverage:

(1) Decline to offer coverage to, or deny enrollment of, an eligible individual; or

(2) Impose any preexisting condition exclusion with respect to such coverage.

(b) An insurer may elect to limit the coverage offered under subsection (a) of this section so long as:

(1) The insurer offers at least two different accident and sickness insurance policy forms, both of which are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals; and

(2) As elected by the insurer:

(A) The insurer offers the policy forms for individual accident and sickness insurance coverage with the largest, and next to the largest, premium volume of all such policy forms offered by the insurer in this state in the period involved; or

(B) The insurer offers a lower-level coverage policy form and a higher-level coverage policy form each of which includes benefits substantially similar to other individual accident and sickness insurance coverage offered by the insurer in this state and each of which is covered under a risk adjustment, risk spreading, or financial subsidization method. The actuarial value of benefits under a lower-level coverage policy form and a higher-level coverage policy form shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(c) The elections made by the insurer under subsection (b) of this section shall apply uniformly to all eligible individuals in this state for that insurer, and shall be effective for policies offered during a period of at least two years. Policy forms which have different riders or different cost-sharing arrangements shall be considered to be different policy forms.

(d) An insurer may deny accident and sickness coverage in the individual market to an eligible individual if the insurer has demonstrated to the satisfaction of the commissioner that:

(1) It does not have the financial reserves necessary to underwrite additional coverage; and

(2) Coverage is denied uniformly to all individuals in the individual market in the state without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.

(e) An insurer denying insurance coverage pursuant to the provisions of subsection (d) of this section may not offer accident and sickness coverage in the individual market for a period of one hundred eighty days after the date coverage is denied or until the insurer has demonstrated to the satisfaction of the commissioner that it has sufficient financial reserves to underwrite additional coverage, whichever is later.

(f) Insurers offering accident and sickness insurance coverage in the individual market through a network plan may:

(1) Limit the individuals who may be enrolled to those who live, reside or work within the service area for the network plan; and

(2) Deny coverage to those individuals within the service area if the insurer has demonstrated to the satisfaction of the commissioner that:

(A) It will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders and enrollees and individual enrollees; and

(B) It is applying this subsection uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.

(g) An insurer denying accident and sickness insurance coverage through a network plan pursuant to the provisions of subsection (f) of this section may not offer coverage in the individual market within its service area for a period of one hundred eighty days after coverage is denied.

(h) The provisions of this section shall not be construed to require that an insurer offering accident and

sickness coverage only in connection with group health plans or through one or more bona fide associations, or both, offer such accident and sickness insurance coverage in the individual market.

(i) An insurer offering accident and sickness insurance coverage in connection with group health plans shall not be deemed to be an insurer offering individual accident and sickness insurance coverage in the individual market solely because such insurer offers a conversion policy.

(j) The requirements of section one-b of this article do not apply to policies issued pursuant to this section. However, premium rate charges for individual accident and sickness policies issued pursuant to this section shall be filed with and approved by the commissioner pursuant to the provisions of article sixteen-b of this chapter.

(k) This section applies to individual accident and sickness insurance coverage offered, sold, issued, renewed or in effect after the thirtieth day of June, one thousand nine hundred ninety-seven.

§33-15-2c. Feasibility study for alternatives to guaranteed issue.

The Legislature finds that alternatives to the provisions of this article relating to guaranteed issue of individual accident and sickness insurance policies do exist but the feasibility of these alternatives are not presently known. Therefore, the commissioner is to perform or have performed a study as to the feasibility of these alternatives and their impact upon the individual market. The results of this study shall be provided to the Legislature during its regular session in the year one thousand nine hundred ninety-eight.

§33-15-2d. Exceptions to guaranteed renewability.

(a) An insurer may nonrenew or discontinue accident and sickness insurance coverage of an individual in the individual market based only on one or more of the following:

(1) The individual has failed to pay premiums or contributions in accordance with the terms of the policy or the insurer has not received timely premium payments;

(2) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;

(3) The insurer is ceasing to offer coverage in accordance with the provisions of section two-e of this article;

(4) In the case of an insurer that offers coverage through a network plan, the individual no longer resides, lives or works in the service area but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals; or

(5) In the case of coverage made available in the individual market only through one or more bona fide associations, the individual's membership in the association ceases but only if coverage is terminated uniformly without regard to any health-status related factor of covered individuals.

(b) This section applies to individual accident and sickness insurance coverage offered, sold, issued, renewed or in effect after the thirtieth day of June, one thousand nine hundred ninety-seven.

§33-15-2e. Discontinuation of particular type of coverage; uniform termination of all coverage; uniform modification of coverage.

(a) An insurer may discontinue offering a particular type of accident and sickness insurance coverage in the individual market only if:

(1) The insurer provides written notice to each individual provided this type of coverage at least ninety days prior to the date of the discontinuation of coverage;

(2) The insurer offers to each individual in the individual market provided this type of coverage the option to purchase any other type of individual accident

and sickness insurance policy currently offered by that insurer; and

(3) The insurer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for coverage.

(b) An insurer may discontinue offering all individual accident and sickness insurance coverage in the individual market offered in this state only if:

(1) The insurer provides written notice to the insurance commissioner and to each insured of the discontinuation at least one hundred eighty days prior to the expiration of coverage; and

(2) All accident and sickness insurance policies issued or delivered for issuance in this state in the individual market are discontinued and coverage under the policies in the individual market is not renewed.

(c) In the case of discontinuation under subsection (b) of this section, the insurer may not provide for the issuance of any accident sickness insurance coverage in the individual market and state during the five-year period beginning on the date of the discontinuation of the last accident and sickness insurance coverage not so renewed.

(d) At the time of renewal, an insurer may modify coverage under an accident and sickness policy only if the modification is consistent with the provisions of this article and article twenty-eight of this chapter and is effective on a uniform basis among all individuals with that policy form. For individuals who are eligible for medicare at the time of renewal, the insurer may modify coverage to reduce benefits by an amount no more than that paid by medicare.

(e) This section applies to individual accident and sickness insurance coverage offered, sold, issued, renewed or in effect after the thirtieth day of June, one thousand nine hundred ninety-seven.

§33-15-2f. Certification of creditable coverage.

An insurer offering accident and sickness insurance coverage pursuant to the provisions of this article shall provide certification of creditable coverage in the same manner as provided in section three-m, article sixteen of this chapter.

§33-15-2g. Applicability.

(a) The requirements of sections two-b, two-d, two-e and two-f of this article do not apply to:

(1) Coverage only for accident, or disability income insurance or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for on-site medical clinics; and

(8) Other similar insurance coverage, which may be specified by rule, under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) The requirements of sections two-b, two-d, two-e and two-f of this article do not apply to the following if provided under a separate policy, certificate, or contract of insurance:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(3) Coverage for only a specified disease or illness;

(4) Hospital indemnity or other fixed indemnity insurance;

(5) Medicare supplement insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under group accident and sickness insurance; and

(6) Any other benefits as may be specified by rule.

§33-15-4e. Benefits for mothers and newborns.

(a) Nothing in this section shall be construed to require a mother to give birth in a hospital or to stay in a hospital for a fixed period of time following the birth of her child. However, an insurer offering accident and sickness insurance coverage under this article may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or her newborn child to less than forty-eight hours following a normal vaginal delivery, or to less than ninety-six hours following a cesarean section, or require a provider to obtain authorization for such length hospital stays. The mother and her newborn child may be discharged prior to the expiration of the minimum length of stay required under this section only in those cases in which the decision to discharge is made by an attending provider in consultation with the mother.

(b) Coverage for maternity and pediatric care shall be provided in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

(c) Benefits provided under this section may be subject to deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital stays in connection with childbirth for a mother or newborn child if the coinsurance or other cost-sharing for any portion of the hospital stay required under subsection (a) of this section is no greater than the coinsurance or cost-sharing for any preceding portion of the stay.

(d) Nothing in this section may be construed to prevent an insurer from negotiating the level and type of reimbursement with a provider for the care provided a mother or newborn child in connection with childbirth.

(e) This section shall not apply with respect to any accident and sickness insurance coverage which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(f) This section shall apply to accident and sickness insurance coverage offered, sold, issued, renewed, or in effect in the individual market on or after the first day of January, one thousand nine hundred ninety-eight.

§33-15-20. Individual medical savings accounts; definitions; ownership; trustees; regulations.

(a) Any individual resident of this state may establish an individual medical savings account to serve as self-insurance for the payment of medical expenses: *Provided,* That an individual establishing an individual medical savings account may designate a percentage of the account assets that may be withdrawn by the individual if not needed for the payment of medical expenses: *Provided, however,* That any amount remaining in an individual medical savings account on the earlier of the date of retirement, at the age of fifty-nine and one-half years or more, of the individual who established the account, or the date of death of that individual, may be withdrawn by the individual or by his or her personal representative for a purpose other than the payment of medical expenses: *Provided further,* That no withdrawal pursuant to this subsection shall be subject to the additional twenty percent tax as provided in subsection (d) of this section. As used in this section, "individual medical savings account" means a trust that meets the definition of "medical savings account" set forth in paragraph (1), subsection (d), section 220 of the Internal Revenue Code of 1986, as amended, when that definition is applied without regard to sub-subparagraph (ii), subparagraph (A) of that paragraph. "Medical expenses" means expenses that fall within the definition of "qualified medical expenses" set forth in paragraph

(2), subsection (d), section 220 of the Internal Revenue Code of 1986, as amended, when that definition is applied without regard to subparagraph (C) of that paragraph.

(b) Any insurer issuing accident and sickness policies in this state in accordance with the provisions of this article may offer a benefit plan including deductibles or copayments combined with individual self-insurance through the establishment of individual medical savings accounts. A benefit plan established pursuant to this subsection shall provide that medical expenses included within deductible or copayment provisions of the accident and sickness policy for the individual or for his or her covered dependents and therefore not payable under that policy be paid by the trustee, either directly or as reimbursement to an individual who has previously paid medical expenses, from the individual medical savings account. A benefit plan may limit payment of medical expenses until the group plan annual deductible is met from the individual medical savings account to expenses which are covered services under the policy.

(c) Within one hundred eighty days of the passage of this legislation, the tax commissioner may promulgate emergency rules as to the keeping of records, the content and form of returns and statements, and the filing of copies of income tax returns and determination by trustees of individual medical savings accounts and by individuals establishing individual medical savings accounts: *Provided,* That for purposes of sections fifteen, fifteen-a and fifteen-b, article three, chapter twenty-nine-a of this code, a sufficient emergency to justify the promulgation of those rules shall be deemed to exist. The power granted by this subsection shall be in addition to the rule-making powers granted to the tax commissioner elsewhere in this code.

(d) If any amount distributed out of an individual medical savings account is used for any purpose other than to defray medical expenses, except as specifically provided in subsection (a) of this section or except for a distribution of account assets pursuant to order of a federal bankruptcy court, the West Virginia personal

income tax of the individual establishing the account, for the taxable year in which the distribution is made shall be increased by an amount equal to twenty percent of the distribution.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-1a. Definitions.

As used in this article:

(a) "Bona fide association" means an association which has been actively in existence for at least five years; has been formed and maintained in good faith for purposes other than obtaining insurance; does not condition membership in the association on any health status-related factor relating to an individual; makes accident and sickness insurance offered through the association available to all members regardless of any health status-related factor relating to members or individuals eligible for coverage through a member; does not make accident and sickness insurance coverage offered through the association available other than in connection with a member of the association; and meets any additional requirements as may be set forth in this chapter or by rule.

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

(c) "Creditable coverage" means, with respect to an individual, coverage of the individual after the thirtieth day of June, one thousand nine hundred ninety-six, under any of the following, other than coverage consisting solely of excepted benefits:

(1) A group health plan;

(2) A health benefit plan;

(3) Medicare Part A or Part B, 42 U.S.C. § 1395 et seq.; Medicaid, 42 U.S.C. §1396a et seq. (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act); Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), 10

U.S.C., Chapter 55; and a medical care program of the Indian Health Service or of a tribal organization;

(4) A health benefits risk pool sponsored by any state of the United States or by the District of Columbia; a health plan offered under 5 U.S.C., chapter 89; a public health plan as defined in regulations promulgated by the federal secretary of health and human services; or a health benefit plan as defined in the Peace Corps Act, 22 U.S.C. § 2504(e).

(d) "Dependent" means an eligible employee's spouse or any unmarried child or stepchild under the age of eighteen or unmarried, dependent child or stepchild under age twenty-three if a full-time student at an accredited school.

(e) "Eligible employee" means an employee, including an individual who either works or resides in this state, who meets all requirements for enrollment in a health benefit plan.

(f) "Excepted benefits" means:

(1) Any policy of liability insurance or contract supplemental thereto; coverage only for accident or disability income insurance or any combination thereof; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; workers' compensation insurance; or other similar insurance under which benefits for medical care are secondary or incidental to other insurance benefits; or

(2) If offered separately, a policy providing benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof, dental or vision benefits, or other similar, limited benefits; or

(3) If offered as independent, noncoordinated benefits under separate policies or certificates, specified disease or illness coverage, hospital indemnity or other fixed indemnity insurance, or coverage, such as medicare supplement insurance, supplemental to a group health plan; or

(4) A policy of accident and sickness insurance covering a period of less than one year.

(g) "Group health plan" means an employee welfare benefit plan, including a church plan or a governmental plan, all as defined in section three of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1003, to the extent that the plan provides medical care;

(h) "Health benefit plan" means benefits consisting of medical care provided directly, through insurance or reimbursement, or indirectly, including items and services paid for as medical care, under any hospital or medical expense incurred policy or certificate; hospital, medical or health service corporation contract; health maintenance organization contract; or plan provided by a multiple-employer trust or a multiple-employer welfare arrangement. "Health benefit plan" does not include excepted benefits.

(i) "Health insurer" means an entity licensed by the commissioner to transact accident and sickness in this state and subject to this chapter. "Health insurer" does not include a group health plan.

(j) "Health status-related factor" means an individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) or disability.

(k) "Medical care" means amounts paid for, or paid for insurance covering, the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, including amounts paid for transportation primarily for and essential to such care.

(l) "Mental health benefits" means benefits with respect to mental health services, as defined under the terms of a group health plan or a health benefit plan offered in connection with the group health plan.

(m) "Network plan" means a health benefit plan under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the health insurer.

(n) "Preexisting condition exclusion" means, with respect to a health benefit plan, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the enrollment date for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before the enrollment date.

§33-16-3a. Same. — Mental health.

Any policy described in this article which shall be delivered or issued or renewed in this state shall make available as benefits to all individual subscribers and members and to all group members if so elected by the subscriber or group, for expenses arising from mental or nervous conditions as hereinafter set forth. Such benefits shall be as described in the standard nomenclature of the American psychiatric association which are at least equal to the following minimum requirements:

(a) In the case of benefits based upon confinement as an inpatient in a mental hospital under the direction and supervision of the department of mental health, or in a private mental hospital licensed by the department of mental health, the period of confinement for which benefits shall be payable shall be at least forty-five days in any calendar year.

(b) In the case of benefits based upon confinement as an inpatient in a licensed or accredited general hospital, such benefits shall be no different than for any other illness.

(c) In the case of outpatient benefits, these shall cover fifty percent of eligible expenses up to five hundred dollars over a twelve-month period, services furnished: (1) By a comprehensive health service organization; (2) by a licensed or accredited hospital; or (3) subject to the approval of the department of mental health, services

furnished by a community mental health center or other mental health clinic or day care center which furnishes mental health services; or (4) consultations or diagnostic or treatment sessions, provided that such services are rendered by a psychotherapist or by a psychologist and do not exceed fifty such sessions over a twelve-month period.

(d) With respect to mental health benefits furnished before the thirieth day of September, two thousand one, to an enrollee of a health benefit plan offered in connection with a group health plan, for a plan year beginning on or after the first day of January, one thousand nine hundred ninety-eight:

(1) Aggregate lifetime limits:

(A) If the health benefit plan does not include an aggregate lifetime limit on substantially all medical and surgical benefits, as defined under the terms of the plan but not including mental health benefits, the plan may not impose any aggregate lifetime limit on mental health benefits;

(B) If the health benefit plan limits the total amount that may be paid with respect to an individual or other coverage unit for substantially all medical and surgical benefits (in this paragraph, "applicable lifetime limit"), the plan shall either apply the applicable lifetime limit to medical and surgical benefits to which it would otherwise apply and to mental health benefits, as defined under the terms of the plan, and not distinguish in the application of the limit between medical and surgical benefits and mental health benefits, or not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit;

(C) If a health benefit plan not previously described in this subdivision includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the commissioner shall propose rules for Legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code under which paragraph (B) of this subdivision shall apply,

substituting an average aggregate lifetime limit for the applicable lifetime limit.

(2) Annual limits:

(A) If a health benefit plan does not include an annual limit on substantially all medical and surgical benefits, as defined under the terms of the plan but not including mental health benefits, the plan may not impose any annual limit on mental health benefits, as defined under the terms of the plan;

(B) If the health benefit plan limits the total amount that may be paid in a twelve-month period with respect to an individual or other coverage unit for substantially all medical and surgical benefits (in this paragraph, "applicable annual limit"), the plan shall either apply the applicable annual limit to medical and surgical benefits to which it would otherwise apply and to mental health benefits, as defined under the terms of the plan, and not distinguish in the application of the limit between medical and surgical benefits and mental health benefits, or not include any annual limit on mental health benefits that is less than the applicable annual limit;

(C) If a health benefit plan not previously described in this subdivision includes no or different annual limits on different categories of medical and surgical benefits, the commissioner shall propose rules for Legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code under which paragraph (B) of this subdivision shall apply, substituting an average annual limit for the applicable annual limit.

(3) For purposes of this subsection, mental health benefits do not include benefits with respect to treatment of substance abuse or chemical dependency. This subsection shall not apply to a health benefit plan if its application results in an increase of at least one percent in the cost under the plan.

(4) If a group health plan or a health insurer offers a participant or beneficiary two or more benefit package

options, this subsection shall apply separately with respect to coverage under each option.

§33-16-3j. Hospital benefits for mothers and newborns.

(a) Nothing in this section shall be construed to require a mother to give birth in a hospital or to stay in the hospital for a fixed period of time following the birth of her child, but if a health benefit plan, for plan years beginning on or after the first day of January, one thousand nine hundred ninety-eight, provides inpatient benefits in connection with childbirth for a mother or her newborn child:

(1) The plan may not restrict benefits for any hospital stay following a normal vaginal delivery to less than forty-eight hours or following a cesarean section to less than ninety-six hours, or require a provider to obtain authorization for such length hospital stays;

(2) The plan must cover maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics or other established professional medical association; and

(3) The mother and her newborn child may be discharged prior to the expiration of the minimum length of stay required under this section only in those cases in which the decision to discharge is made by an attending provider in consultation with the mother.

(b) Benefits provided for under this section may be made subject to deductibles, coinsurance or other cost-sharing if such cost-sharing is no greater than cost-sharing for any preceding portion of the mother's or newborn child's hospital stay.

(c) Nothing in this section shall be construed to prevent a health insurer from negotiating with a provider the level and type of reimbursement for inpatient maternity or newborn care provided under a health benefit plan.

§33-16-3k. Limitations on preexisting condition exclusions for health benefit plans.

(a) (1) For plan years beginning after the thirtieth day of June, one thousand nine hundred ninety-seven, a health benefit plan issued in connection with a group health plan may not impose a preexisting condition exclusion with respect to an employee or a dependent of an employee for losses incurred by the employee or dependent more than twelve months (or eighteen months for a late enrollee) after the earlier of the individual's date of enrollment in the health benefit plan or the first day of a waiting period for enrollment in the plan. Genetic information may not be treated as a condition for which a preexisting condition exclusion may be imposed absent a diagnosis of the condition related to the genetic information.

(2) A health benefit plan may impose a preexisting condition exclusion only if such condition relates to a physical or mental condition, regardless of its cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollee's enrollment date.

(3) A health benefit plan may impose no preexisting condition exclusion relating to pregnancy or in the case of a newborn covered under creditable coverage within thirty days of birth or a child adopted before the age of eighteen and covered under creditable coverage within thirty days of adoption or placement for adoption.

(b) A health maintenance organization that does not impose a preexisting condition exclusion allowed under subsection (a) of this section with respect to any particular coverage option may:

(1) Impose an affiliation period for that coverage option if the affiliation period is applied uniformly without regard to any health status-related factors and does not exceed two months (three months for a late enrollee). For purposes of this article, "affiliation period" means a period that begins on an employee's or dependent's enrollment date, runs concurrently with any

waiting period under the group health plan, must expire before coverage is effective and during which the health maintenance organization need not provide medical care and may not charge any premium to the employee or dependent; or

(2) Use other alternatives approved by the commissioner to address adverse selection.

(c) Any preexisting condition exclusion period, including any waiting period or affiliation period prior to the effective date of coverage, shall be reduced by the aggregate of the periods of creditable coverage applicable to the enrollee as of the enrollment date.

§33-16-3l. Renewability and modification of health benefit plans.

(a) A health insurer may refuse to renew a health benefit plan issued in connection with a group health plan after complying with all applicable provisions of this chapter and only for one of the following reasons:

(1) The policyholder's failure to pay premiums or the carrier's failure to receive timely premium payments;

(2) Fraud or intentional misrepresentation of material fact by the policyholder;

(3) The policyholder's failure to comply with a material plan provision relating to contribution or group participation rules;

(4) The health insurer elects to discontinue offering health benefit plans:

(A) Of a particular type, if the health insurer gives notice to each policyholder of such plan and to all covered employees or members and dependents at least ninety days before the date such coverage is discontinued: *Provided,* That a health insurer electing to discontinue health benefit plans to small employers shall comply with the requirements of section seven, article sixteen-d of this chapter. The health insurer shall offer each such policyholder the option to purchase any other health benefit plan offered by the health insurer to employers.

In electing to discontinue health benefit plans of a particular type and in offering coverage under the preceding sentence, the health insurer shall act uniformly without regard to policyholders' claims experience or any health status-related factor relating to any covered employee, member or dependent or new employees, members or dependents who may become eligible for coverage; or

(B) Of all types, if the health insurer gives notice to the commissioner and to each policyholder and all covered employees or members and dependents at least one hundred eighty days before the date plans are discontinued: *Provided,* That a health insurer electing to discontinue health benefit plans to small employers shall comply with the requirements of section seven, article sixteen-d of this chapter. The health insurer shall discontinue all, and not renew any, health benefit plans issued pursuant to this article. The health insurer may not issue any health benefit plan pursuant to this article for a five-year period beginning on the date the last discontinued health benefit plan is not renewed;

(5) For a health insurer offering coverage under a network plan, the health insurer no longer has any enrollees of the network plan who live, reside or work in the plan's service area; or

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

(b) Subject to other requirements of this chapter, a health insurer may modify a health benefit plan issued in connection with a group health plan when the health benefit plan is renewed.

§33-16-3m. Creditable coverage.

(a) (1) A health insurer shall certify an enrollee's creditable coverage at the time an enrollee:

(A) Ceases to be covered under a health benefit plan issued in connection with a group health plan, including coverage under a COBRA continuation provision. For purposes of this article, "COBRA continuation provision" means any of the following:

(1) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines;

(2) Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974, other than Section 609 of such act; or

(3) Title XXII of the Public Health Service Act;

(B) Ceases to be covered under a COBRA continuation provision; and

(C) Requests certification, but no later than twenty-four months after cessation of coverage under the health benefit plan.

(2) The health insurer shall provide the enrollee a written certification of:

(A) The period of creditable coverage under the health benefit plan, including coverage, if any, under a COBRA continuation provision; and

(B) The waiting period, if any, and affiliation period, if applicable, for any coverage under the health benefit plan.

(b) For purposes of reducing an enrollee's preexisting condition exclusion period, creditable coverage shall not be counted if, after such period and before an employee's or dependent's enrollment in a health benefit plan issued in connection with a group health plan, there was a period of sixty-three days or more during all of which the individual was not covered under any creditable coverage. For purposes of this subsection, a sixty-three-day period may not include any waiting

period or affiliation period prior to the effective date of an individual's coverage.

(c) For purposes of reducing an enrollee's preexisting condition exclusion period, a health insurer:

(1) Shall count a period of creditable coverage without regard to specific benefits covered during the period; or

(2) May elect to apply creditable coverage based upon each of several classes or categories of benefits in accordance with rules promulgated by the commissioner. A health insurer shall make such an election on a uniform basis for all enrollees and shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

§33-16-3n. Eligibility for enrollment.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, a health insurer offering coverage in connection with a group health plan may not, for plan years beginning after the thirtieth day of June, one thousand nine hundred ninety-seven, establish rules for eligibility, including continued eligibility, of any employee or dependent to enroll under a health benefit plan based on a health status-related factor.

(b) For plan years beginning after the thirtieth day of June, one thousand nine hundred ninety-seven, a health benefit plan offered in connection with a group health plan shall provide that an employee or dependent of an employee who is eligible, but not enrolled, under terms of a health benefit plan may enroll under terms of the plan if the employee or dependent:

(1) Was covered under other creditable coverage when coverage was previously offered to the employee or dependent and, if required by the insurer, the employee stated in writing that the existence of other creditable coverage was the reason for declining enrollment under the health benefit plan;

(2) Lost coverage under the other creditable coverage because of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, exhaustion of COBRA continuation coverage or termination of the employer's contributions towards the other creditable coverage; and

(3) The employee requests enrollment no more than thirty days after loss of the other creditable coverage.

(c) For plan years beginning after the thirtieth day of June, one thousand nine hundred ninety-seven, if a health benefit plan makes coverage available to an employee's dependents, the plan shall provide that if an employee is enrolled under the plan or has met any waiting period requirement and is eligible for enrollment but for a failure to enroll during a previous enrollment period:

(1) The employee or a person who becomes a dependent of the employee through marriage, birth, adoption or placement for adoption may be enrolled under the plan, and in the case of the birth or adoption of a child, the employee's spouse who is otherwise eligible for coverage may be enrolled as a dependent, during a period of at least thirty days beginning on the later of the date dependent coverage is made available or the date of the marriage, birth, adoption or placement for adoption; and

(2) If the employee requests enrollment of a dependent during the first thirty days that dependent coverage is available, the dependent's coverage shall become effective:

(A) In the case of marriage, no later than the first day of the first month after the date the completed enrollment request is received; or

(B) In the case of a dependent's birth, adoption or placement for adoption, as of the date of birth, adoption or placement for adoption.

§33-16-15. Individual medical savings accounts; definitions; ownership; contributions; trustees; regulations.

(a) Any insurer issuing group accident and sickness policies in this state, the public employees insurance agency and any employer offering a health benefit plan pursuant to the Employee Retirement Income Security Act of 1974, as amended, may offer a benefit plan including deductibles or copayments combined with employee self-insurance through the establishment of individual medical savings accounts. An insurer offering a benefit plan consisting of deductibles or copayments combined with employee self-insurance and individual medical savings accounts shall not be deemed to be an insurer offering individual accident and sickness insurance coverage solely because the insurer offers such a benefit plan. Notwithstanding any provision of this section, an employer may not compel an employee as a condition of employment to contribute any amount to an individual medical savings account which has been established for the employee, or to accept contributions to an individual medical savings account in lieu of other compenstion or benefits. An employer may not charge an employee a fee, by any name whatsoever, in return for establishing an individual medical savings account for the employee: *Provided,* That a reasonable fee may be charged for any necessary services rendered in the establishment of the individual medical savings account and which fee is fully disclosed to the employee or account holder: *Provided, however,* That any qualified person serving as trustee of an individual medical savings account established for any employee or account holder, may impose reasonable fees, charges and expenses for administration.

An employee establishing an individual medical savings account, or for whom an account is established by an employer, may designate a percentage of the employee's contributions, if any, to that account that may be withdrawn by the employee if not needed for the payment of medical expenses: *Provided,* That any amount remaining in an individual medical savings account on the earlier of the date of retirement, at the age of fifty-nine and one-half years or more, of the employee or the date of death of the employee, may be withdrawn by the employee or by his or her personal representative for a purpose other than the payment of medical

expenses: *Provided, however,* That no withdrawal pursuant to this subsection shall be subject to the additional twenty percent tax as provided in subsection (d) of this section. As used in this section, "individual medical savings account" means a trust that meets the definition of "medical savings account" set forth in paragraph (1), subsection (d), section 220 of the Internal Revenue Code of 1986, as amended, when that definition is applied without regard to sub-subparagraph (ii), subparagraph (A) of that paragraph. "Medical expenses" means expenses that fall within the definition of "qualified medical expenses" set forth in paragraph (2), subsection (d), Section 220 of the Internal Revenue Code of 1986, as amended, when that definition is applied without regard to subparagraph (C) of that paragraph.

(b) A benefit plan established pursuant to this section shall provide that medical expenses included within deductible or copayment provisions of the group accident and sickness policy and therefore not payable under the group policy for the employee or for his or her covered dependents be paid by the trustee, either directly or as reimbursement to an employee who has previously paid medical expenses, from the individual medical savings account. A benefit plan may limit payment of medical expenses until the group plan annual deductible is met from the medical savings account to expenses which are covered services under the group policy. Combined plans are subject to the protections afforded by article twenty-six-a of this chapter.

(c) Within one hundred eighty days of the passage of this legislation, the tax commissioner may promulgate emergency rules as to the keeping of records, the content and form of returns and statements, and the filing of copies of income tax returns and determination by trustees of individual medical savings accounts and by employees establishing those accounts or for whom those accounts are established: *Provided,* That for purposes of sections fifteen, fifteen-a and fifteen-b, article three, chapter twenty-nine-a of this code, a sufficient emergency to justify the promulgation of those rules shall be deemed to exist. The power granted by this subsection shall be in

addition to the rule-making power granted to the tax commissioner elsewhere in this code.

(d) If any amount distributed out of an individual medical savings account is used for any purpose other than to defray medical expenses, except as specifically provided in subsection (a) of this section or except for a distribution of account assets pursuant to order of a federal bankruptcy court, the West Virginia personal income tax of the employee establishing the account or for whom the account is established, for the taxable year in which the distribution is made shall be increased by an amount equal to twenty percent of the distribution.

§33-16-17. Commissioner to propose rules.

Pursuant to chapter twenty-nine-a of this code, the commissioner shall have the power to propose rules, subject to legislative approval, necessary to implement the provisions of this article.

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

§33-16D-2. Definitions.

As used in this article:

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

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

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

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

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

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

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

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

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

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

(2) A small employer carrier may establish no more than two additional groupings under subdivision (1) of this subsection on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

(3) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the

commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

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

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

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

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

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

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

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

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

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

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

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

(q) "Rating period" means the calendar period of at least twelve months for which premium rates established

by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

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

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

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

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

(b) For plan years beginning after the thirtieth day of June, one thousand nine hundred ninety-seven, in which the plan has, on the first day of the plan year, at least two enrollees who are current employees, each carrier shall accept every small employer that applies for coverage under a health benefit plan, unless such health benefit plan is made available only through a bona fide association, and consistent with public law 104-191 (Public Health Service Act section 2711 (a) (1) (B), shall accept for enrollment in the plan every employee of the small employer, including dependents, when an employee or dependent first becomes eligible to enroll under terms of

the plan and under the rules of the carrier that are uniformly applicable to small employers. This subsection shall not apply to:

(1) A network plan if the carrier:

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

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

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

(c) All carriers subject to this article shall file any marketing information upon request of the commissioner. The commissioner shall review said information and shall have the authority to take appropriate action to eliminate discriminatory marketing practices, including imposing fines on violators of this section of not more than ten thousand dollars. Upon a second violation of this section,

the commissioner shall have the authority to revoke the violator's license to transact insurance.

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

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

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

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

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

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

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

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

(A) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small

employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;

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

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

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

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

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

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

characteristics, consistently with respect to all small employers in a class of business.

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

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

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

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

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

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

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

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

(a) A health benefit plan subject to this article shall be renewable to all eligible employees at the option of the small employer: *Provided,* That a carrier may refuse to renew a health benefit plan for plan years beginning on or before the thirtieth day of June, one thousand nine hundred ninety-seven, for any of the following reasons:

(1) Nonpayment of required premiums;

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

(3) Noncompliance with plan provisions;

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

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

(b) For plan years beginning after the thirtieth day of June, one thousand nine hundred ninety-seven, in which the plan has, on the first day of the plan year, at least two enrollees who are current employees, a health benefit plan shall be renewable to all eligible employees at the option

of the small employer, and a carrier may refuse to renew a health benefit plan only for one of the following reasons:

(1) Nonpayment of required premiums;

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

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

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

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

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

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

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

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

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

(d) For plan years beginning after the thirtieth day of June, one thousand nine hundred ninety-seven, in which the plan has, on the first day of the plan year, at least two enrollees who are current employees, a carrier may elect to discontinue offering health benefit plans:

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

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

beginning on the date the last discontinued health benefit plan is not renewed.

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

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

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

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

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

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

(4) The provisions relating to renewability of coverage;

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

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

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

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

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

§33-16D-11. Effective date.

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

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

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

(a) Preexisting conditions provisions may not exclude coverage for a period beyond twelve months following an individual's effective date of coverage and may only relate to conditions which had, during the twelve months immediately preceding the effective date of coverage, manifested themselves in such a manner as

would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received, or as to a pregnancy existing on the effective day of coverage. For plan years beginning after the thirtieth day of June, one thousand nine hundred ninety-seven, in which the plan has, on the first day of the plan year, at least two enrollees who are current employees, a health benefit plan shall meet all requirements set forth in section three-k, article sixteen of this chapter (preexisting condition exclusions).

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

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

(d) For plan years beginning after the thirtieth day of June, one thousand nine hundred ninety-seven, in which

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

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

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

ARTICLE 23. FRATERNAL BENEFIT SOCIETIES.

§33-23-24. Filing and approval of accident and sickness insurance certificates.

(a) No domestic, foreign or alien society licensed in this state shall issue or deliver in this state any certificate or other evidence of any contract of accident and sickness insurance unless and until the form thereof, together with the form of application and all riders or endorsements for use in connection therewith, shall have been filed with the commissioner and approved by him or her as conforming to reasonable rules from time to time in effect and as not inconsistent with any other provisions of law applicable thereto. The commissioner shall, within a reasonable time after the filing of any form, notify the society filing the form of the approval or disapproval of the form. The commissioner may in his or her discretion approve any form which contains provisions more favorable to the members than the ones required.

(b) Pursuant to chapter twenty-nine-a of this code, the commissioner may promulgate rules necessary to

implement the provisions of this section, and such rules shall conform, as far as practicable, to the provisions of article fifteen (Accident and Sickness Insurance) and article sixteen (Group Accident and Sickness Insurance) of this chapter.

(1) For any certificate or other evidence of coverage issued before the first day of July, one thousand nine hundred ninety-seven, and for any certificate or other evidence of coverage under a health benefit plan issued on or after the first day of July, one thousand nine hundred ninety-seven, other than in connection with a group health plan, where the commissioner deems inapplicable, either in part or in their entirety, the provisions of articles fifteen or sixteen of this chapter, the commissioner may prescribe the portions or summary thereof of the contract to be printed on the certificate issued to the member. For purposes of this subsection, the terms "group health plan" and "health benefit plan" have the meanings set forth in section one-a, article sixteen of this chapter.

(2) For any certificate or other evidence of individual coverage issued or renewed on or after the first day of July, one thousand nine hundred ninety-seven, the society shall comply with all provisions of article fifteen of this chapter. For any certificate or other evidence of coverage under a health benefit plan issued in connection with a group health plan on or after the first day of July, one thousand nine hundred ninety-seven, the society shall comply with all provisions of article sixteen of this chapter, and for a health benefit plan issued to a small employer, as defined in section two, article sixteen-d of this chapter, with all provisions of article sixteen-d of this chapter.

(c) Any filing made hereunder shall be deemed approved unless disapproved within sixty days from the date of such filing.

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

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

Every corporation defined in section two of this article is hereby declared to be a scientific, nonprofit institution and exempt from the payment of all property and other taxes. Every corporation, to the same extent the provisions are applicable to insurers transacting similar kinds of insurance and not inconsistent with the provisions of this article, shall be governed by and be subject to the provisions as hereinbelow indicated, of the following articles of this chapter: Article two (insurance commissioner), except that, under section nine of said article, examinations shall be conducted at least once every four years; article four (general provisions), except that section sixteen of said article shall not be applicable thereto; section thirty-four, article six (fee for form and rate filing); article six-c (guaranteed loss ratio); article seven (assets and liabilities); article eleven (unfair trade practices); article twelve (agents, brokers and solicitors), except that the agent's license fee shall be twenty-five dollars; section two-a, article fifteen (definitions); section two-b, article fifteen (guaranteed issue); section two-d, article fifteen (exception to guaranteed renewability); section two-e, article fifteen (discontinuation of coverage); section two-f, article fifteen (certification of creditable coverage); section two-g, article fifteen (applicability); section four-e, article fifteen (benefits for mothers and newborns); section fourteen, article fifteen (individual accident and sickness insurance); section sixteen, article fifteen (coverage of children); section eighteen, article fifteen (equal treatment of state agency); section nineteen, article fifteen (coordination of benefits with medicaid); article fifteen-a (long-term care insurance); article fifteen-c (diabetes insurance); section three, article sixteen (required policy provisions); section three-a, article sixteen (mental health); section three-c, article sixteen (group accident and sickness insurance); section three-d, article sixteen (medicare supplement insurance); section three-f, article sixteen (treatment of temporomandibular joint disorder and craniomandibular disorder); section three-j, article sixteen (benefits for mothers and newborns); section three-k, article sixteen (preexisting condition

exclusions); section three-l, article sixteen (guaranteed renewability); section three-m, article sixteen (creditable coverage); section three-n, article sixteen (eligibility for enrollment); section eleven, article sixteen (coverage of children); section thirteen, article sixteen (equal treatment of state agency); section fourteen, article sixteen (coordination of benefits with medicaid); section sixteen, article sixteen (diabetes insurance); article sixteen-a (group health insurance conversion); article sixteen-c (small employer group policies); article sixteen-d (marketing and rate practices for small employers); article twenty-six-a (West Virginia life and health insurance guaranty association act), after the first day of October, one thousand nine hundred ninety-one; article twenty-seven (insurance holding company systems); article twenty-eight (individual accident and sickness insurance minimum standards); article thirty-three (annual audited financial report); article thirty-four (administrative supervision); article thirty-four-a (standards and commissioner's authority for companies deemed to be in hazardous financial condition); article thirty-five (criminal sanctions for failure to report impairment); and article thirty-seven (managing general agents); and article forty-one (privileges and immunity), and no other provision of this chapter may apply to these corporations unless specifically made applicable by the provisions of this article. If, however, the corporation is converted into a corporation organized for a pecuniary profit or if it transacts business without having obtained a license as required by section five of this article, it shall thereupon forfeit its right to these exemptions.

ARTICLE 25. HEALTH CARE CORPORATIONS.

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

Corporations organized under this article are subject to supervision and regulation of the insurance commissioner. The corporations organized under this article, to the same extent these provisions are applicable to insurers transacting similar kinds of insurance and not inconsistent with the provisions of this article, shall be

governed by and be subject to the provisions as hereinbelow indicated of the following articles of this chapter: Article four (general provisions), except that section sixteen of said article shall not be applicable thereto; article six-c (guaranteed loss ratio); article seven (assets and liabilities); article eight (investments); article ten (rehabilitation and liquidation); section two-a, article fifteen (definitions); section two-b, article fifteen (guaranteed issue); section two-d, article fifteen (exception to guaranteed renewability); section two-e, article fifteen (discontinuation of coverage); section two-f, article fifteen (certification of creditable coverage); section two-g, article fifteen (applicability); section four-e, article fifteen (benefits for mothers and newborns); section fourteen, article fifteen (individual accident and sickness insurance); section sixteen, article fifteen (coverage of children); section eighteen, article fifteen (equal treatment of state agency); section nineteen, article fifteen (coordination of benefits with medicaid); article fifteen-c (diabetes insurance); section three, article sixteen (required policy provisions); section three-a, article sixteen (mental health); section three-j, article sixteen (benefits for mothers and newborns); section three-k, article sixteen (preexisting condition exclusions); section three-l, article sixteen (guaranteed renewability); section three-m, article sixteen (creditable coverage); section three-n, article sixteen (eligibility for enrollment); section eleven, article sixteen (coverage of children); section thirteen, article sixteen (equal treatment of state agency); section fourteen, article sixteen (coordination of benefits with medicaid); section sixteen, article sixteen (diabetes insurance); article sixteen-a (group health insurance conversion); article sixteen-c (small employer group policies); article sixteen-d (marketing and rate practices for small employers); article twenty-six-a (West Virginia life and health insurance guaranty association act); article twenty-seven (insurance holding company systems); article thirty-three (annual audited financial report); article thirty-four-a (standards and commissioner's authority for companies deemed to be in hazardous financial condition); article thirty-five (criminal sanctions for failure to report impairment); article thirty-seven (managing general

agents); and article forty-one (privileges and immunity); and no other provision of this chapter may apply to these corporations unless specifically made applicable by the provisions of this article.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

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

(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 shall 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) Factually accurate advertising or solicitation regarding the range of services provided, the premiums and copayments charged, the sites of services and hours of operation, and any other quantifiable, nonprofessional aspects of its operation by a health maintenance organization granted a certificate of authority, or its representative shall not be construed to violate any provision of law relating to solicitation or advertising by health professions: *Provided,* That nothing contained 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 shall 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 provisions of section fifteen and twenty, article four (general provisions); section seventeen, article six (noncomplying forms); article six-c (guaranteed loss ratio); article seven (assets and liabilities); article eight (investments); article nine (administration of deposits); article twelve (agents, brokers, solicitors and excess line); section two-a, article fifteen (definitions); section two-b, article fifteen (guaranteed issue); section two-d, article fifteen (exception to guaranteed renewability); section two-e, article fifteen (discontinuation of coverage); section two-f, article fifteen (certification of creditable coverage); section two-g, article fifteen (applicability); section four-e, article fifteen (benefits for mothers and newborns); section fourteen, article fifteen (individual accident and sickness insurance); section sixteen, article fifteen (coverage of children); 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); article fifteen-c (diabetes insurance); section three, article sixteen (required policy provisions); section three-a, article sixteen (mental health); section three-f, article sixteen (treatment of temporomandibular disorder and craniomandibular disorder); section three-j, article sixteen (benefits for mothers and newborns); section three-k, article sixteen (preexisting condition exclusions); section three-l, article sixteen (guaranteed renewability); section three-m, article sixteen (creditable coverage); section three-n, article (eligibility for enrollment); section eleven, article sixteen (coverage of children); section thirteen, article sixteen (equal treatment of state agency); section fourteen, article sixteen (coordination of benefits with medicaid); section sixteen, article sixteen (diabetes insurance); article sixteen-a (group health insurance conversion); article sixteen-c (small employer group policies); article sixteen-d (marketing and rate practices for small employers); article twenty-seven (insurance holding

company systems); article thirty-four-a (standards and commissioner's authority for companies deemed to be in hazardous financial condition); article thirty-five (criminal sanctions for failure to report impairment); article thirty-seven (managing general agents); and article thirty-nine (disclosure of material transactions); and article forty-one (privileges and immunity) shall be applicable to any health maintenance organization granted a certificate of authority under this article. In circumstances where the code provisions made applicable to health maintenance organizations by this section 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.

(f) A health maintenance organization granted a certificate of authority under this article shall be exempt from paying municipal business and occupation taxes on gross income it receives from its enrollees, or from their employers or others on their behalf, for health care items or services provided directly or indirectly by the health maintenance organization. This exemption applies to all taxable years through the thirty-first day of December, one thousand nine hundred ninety-six. The commissioner and the tax department shall conduct a study of the appropriations of imposition of the municipal business and occupation tax or other tax on health maintenance organizations, and shall report to the regular session of the Legislature, one thousand nine hundred ninety-seven, on their findings, conclusions and recommendations, together with drafts of any legislation necessary to effectuate their recommendations.

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

Chairman Senate Committee

Chairman House Committee

Originating in the House.

Takes effect from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker of the House of Delegates

The within is approved this the 7th day of May, 1997.

Governor

PRESENTED TO THE
GOVERNOR
Date 4/29/97
Time 3:00 pm