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# WEST VIRGINIA LEGISLATURE

REGULAR SESSION, 1997



# ENROLLED

HOUSE BILL No. 2667

Mr. Speaker, Mr. Kiss and Ashley

(By Delegate \_\_\_\_\_ [By Request of the Executive] \_\_\_\_\_ )



Passed \_\_\_\_\_ April 12, \_\_\_\_\_ 1997

In Effect \_\_\_\_\_ From \_\_\_\_\_ Passage

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BY REQUEST OF THE EXECUTIVE

## ENROLLED

COMMITTEE SUBSTITUTE

FOR

# H. B. 2667

(BY MR. SPEAKER, MR. KISS, AND DELEGATE ASHLEY)  
[BY REQUEST OF THE EXECUTIVE]

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

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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.**

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

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

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

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

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

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

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

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

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

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

**§33-15-2a. Definitions.**

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

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

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

27 (c) “COBRA continuation provision” means any of  
28 the following:

29 (1) Section 4980B of the Internal Revenue Code of  
30 1986, other than subsection (f)(1) of such section insofar  
31 as it relates to pediatric vaccines;

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

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

36 (d) “Creditable coverage” means, with respect to an  
37 individual, coverage of the individual under any of the  
38 following:

39 (1) A group health plan;

40 (2) Accident and sickness insurance coverage;

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

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

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

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

48 (7) A state health benefits risk pool;

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

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

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

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

57 (e) “Eligible individual” means an individual:

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

17 (2) As elected by the insurer:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 and sickness insurance policy currently offered by that  
11 insurer; and

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

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

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

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

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

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

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

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

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

**§33-15-2g. Applicability.**

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

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

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

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

9 (4) Workers' compensation or similar insurance;

10 (5) Automobile medical payment insurance;

11 (6) Credit-only insurance;

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

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

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

20 (1) Limited scope dental or vision benefits;

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

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

25 (4) Hospital indemnity or other fixed indemnity  
26 insurance;

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

**ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.**

**§33-16-1a. Definitions.**

1 As used in this article:

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

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

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

24 (1) A group health plan;

25 (2) A health benefit plan;

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

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

33 (4) A health benefits risk pool sponsored by any state  
34 of the United States or by the District of Columbia; a  
35 health plan offered under 5 U.S.C., chapter 89; a public  
36 health plan as defined in regulations promulgated by the  
37 federal secretary of health and human services; or a health  
38 benefit plan as defined in the Peace Corps Act, 22 U.S.C.  
39 § 2504(e).

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

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

49 (f) "Excepted benefits" means:

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

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

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

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

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

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

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

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

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

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

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

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

**§33-16-3a. Same. — Mental health.**

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

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

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

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

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

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

40 (1) Aggregate lifetime limits:

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

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

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

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

68 (2) Annual limits:

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**§33-16-31. Renewability and modification of health benefit plans.**

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

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

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

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

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

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

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

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

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

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

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

**§33-16-3m. Creditable coverage.**

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

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

8 (1) Section 4980B of the Internal Revenue Code of  
9 1986, other than subsection (f)(1) of such section insofar  
10 as it relates to pediatric vaccines;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (a) Any insurer issuing group accident and sickness  
2 policies in this state, the public employees insurance  
3 agency and any employer offering a health benefit plan  
4 pursuant to the Employee Retirement Income Security Act  
5 of 1974, as amended, may offer a benefit plan including  
6 deductibles or copayments combined with employee  
7 self-insurance through the establishment of individual  
8 medical savings accounts. An insurer offering a benefit  
9 plan consisting of deductibles or copayments combined  
10 with employee self-insurance and individual medical  
11 savings accounts shall not be deemed to be an insurer  
12 offering individual accident and sickness insurance  
13 coverage solely because the insurer offers such a benefit  
14 plan. Notwithstanding any provision of this section, an  
15 employer may not compel an employee as a condition of  
16 employment to contribute any amount to an individual  
17 medical savings account which has been established for  
18 the employee, or to accept contributions to an individual  
19 medical savings account in lieu of other compensation or  
20 benefits. An employer may not charge an employee a fee,  
21 by any name whatsoever, in return for establishing an  
22 individual medical savings account for the employee:  
23 *Provided*, That a reasonable fee may be charged for any  
24 necessary services rendered in the establishment of the  
25 individual medical savings account and which fee is fully  
26 disclosed to the employee or account holder: *Provided*,  
27 *however*, That any qualified person serving as trustee of  
28 an individual medical savings account established for any  
29 employee or account holder, may impose reasonable fees,  
30 charges and expenses for administration.

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



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

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

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

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

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

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

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

**ARTICLE 16D. MARKETING AND RATE PRACTICES FOR  
SMALL EMPLOYER ACCIDENT AND SICK-  
NESS INSURANCE POLICIES.**

**§33-16D-2. Definitions.**

1 As used in this article:

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

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

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

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

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

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

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

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

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

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

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

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

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

56 (f) "Commissioner" means the insurance commis-  
57 sioner of West Virginia.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 (1) A network plan if the carrier:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

7 (1) Nonpayment of required premiums;

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

10 (3) Noncompliance with plan provisions;

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

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

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

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

25 (1) Nonpayment of required premiums;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 (4) The provisions relating to renewability of  
17 coverage;

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

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

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

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

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

**§33-16D-11. Effective date.**

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

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

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

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

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

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

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

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

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

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

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

**ARTICLE 23. FRATERNAL BENEFIT SOCIETIES.**

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

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

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



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

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

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

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

**ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL  
SERVICE CORPORATIONS, DENTAL SERVICE  
CORPORATIONS AND HEALTH SERVICE COR-  
PORATIONS.**

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

1 Every corporation defined in section two of this  
2 article is hereby declared to be a scientific, nonprofit  
3 institution and exempt from the payment of all property  
4 and other taxes. Every corporation, to the same extent the  
5 provisions are applicable to insurers transacting similar  
6 kinds of insurance and not inconsistent with the provisions  
7 of this article, shall be governed by and be subject to the  
8 provisions as hereinbelow indicated, of the following  
9 articles of this chapter: Article two (insurance  
10 commissioner), except that, under section nine of said  
11 article, examinations shall be conducted at least once every  
12 four years; article four (general provisions), except that  
13 section sixteen of said article shall not be applicable  
14 thereto; section thirty-four, article six (fee for form and  
15 rate filing); article six-c (guaranteed loss ratio); article  
16 seven (assets and liabilities); article eleven (unfair trade  
17 practices); article twelve (agents, brokers and solicitors),  
18 except that the agent's license fee shall be twenty-five  
19 dollars; section two-a, article fifteen (definitions); section  
20 two-b, article fifteen (guaranteed issue); section two-d,  
21 article fifteen (exception to guaranteed renewability);  
22 section two-e, article fifteen (discontinuation of coverage);  
23 section two-f, article fifteen (certification of creditable  
24 coverage); section two-g, article fifteen (applicability);  
25 section four-e, article fifteen (benefits for mothers and  
26 newborns); section fourteen, article fifteen (individual  
27 accident and sickness insurance); section sixteen, article  
28 fifteen (coverage of children); section eighteen, article  
29 fifteen (equal treatment of state agency); section nineteen,  
30 article fifteen (coordination of benefits with medicaid);  
31 article fifteen-a (long-term care insurance); article  
32 fifteen-c (diabetes insurance); section three, article sixteen  
33 (required policy provisions); section three-a, article sixteen  
34 (mental health); section three-c, article sixteen (group  
35 accident and sickness insurance); section three-d, article  
36 sixteen (medicare supplement insurance); section three-f,  
37 article sixteen (treatment of temporomandibular joint  
38 disorder and craniomandibular disorder); section three-j,  
39 article sixteen (benefits for mothers and newborns);  
40 section three-k, article sixteen (preexisting condition)

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

**ARTICLE 25. HEALTH CARE CORPORATIONS.**

**§33-25-6. Supervision and regulation by insurance commis-  
sioner; exemption from insurance laws.**

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

7 governed by and be subject to the provisions as  
8 hereinbelow indicated of the following articles of this  
9 chapter: Article four (general provisions), except that  
10 section sixteen of said article shall not be applicable  
11 thereto; article six-c (guaranteed loss ratio); article seven  
12 (assets and liabilities); article eight (investments); article  
13 ten (rehabilitation and liquidation); section two-a, article  
14 fifteen (definitions); section two-b, article fifteen  
15 (guaranteed issue); section two-d, article fifteen (exception  
16 to guaranteed renewability); section two-e, article fifteen  
17 (discontinuation of coverage); section two-f, article fifteen  
18 (certification of creditable coverage); section two-g, article  
19 fifteen (applicability); section four-e, article fifteen  
20 (benefits for mothers and newborns); section fourteen,  
21 article fifteen (individual accident and sickness insurance);  
22 section sixteen, article fifteen (coverage of children);  
23 section eighteen, article fifteen (equal treatment of state  
24 agency); section nineteen, article fifteen (coordination of  
25 benefits with medicaid); article fifteen-c (diabetes  
26 insurance); section three, article sixteen (required policy  
27 provisions); section three-a, article sixteen (mental  
28 health); section three-j, article sixteen (benefits for  
29 mothers and newborns); section three-k, article sixteen  
30 (preexisting condition exclusions); section three-l, article  
31 sixteen (guaranteed renewability); section three-m, article  
32 sixteen (creditable coverage); section three-n, article  
33 sixteen (eligibility for enrollment); section eleven, article  
34 sixteen (coverage of children); section thirteen, article  
35 sixteen (equal treatment of state agency); section fourteen,  
36 article sixteen (coordination of benefits with medicaid);  
37 section sixteen, article sixteen (diabetes insurance); article  
38 sixteen-a (group health insurance conversion); article  
39 sixteen-c (small employer group policies); article sixteen-  
40 d (marketing and rate practices for small employers);  
41 article twenty-six-a (West Virginia life and health  
42 insurance guaranty association act); article twenty-seven  
43 (insurance holding company systems); article thirty-three  
44 (annual audited financial report); article thirty-four-a  
45 (standards and commissioner's authority for companies  
46 deemed to be in hazardous financial condition); article  
47 thirty-five (criminal sanctions for failure to report  
48 impairment); article thirty-seven (managing general

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

**ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.**

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

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

21 (b) Factually accurate advertising or solicitation  
22 regarding the range of services provided, the premiums  
23 and copayments charged, the sites of services and hours of  
24 operation, and any other quantifiable, nonprofessional  
25 aspects of its operation by a health maintenance  
26 organization granted a certificate of authority, or its  
27 representative shall not be construed to violate any  
28 provision of law relating to solicitation or advertising by  
29 health professions: *Provided*, That nothing contained in  
30 this subsection shall be construed as authorizing any  
31 solicitation or advertising which identifies or refers to any  
32 individual provider or makes any qualitative judgment  
33 concerning any provider.

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

38 (d) The provisions of section fifteen and twenty,  
39 article four (general provisions); section seventeen, article  
40 six (noncomplying forms); article six-c (guaranteed loss  
41 ratio); article seven (assets and liabilities); article eight  
42 (investments); article nine (administration of deposits);  
43 article twelve (agents, brokers, solicitors and excess line);  
44 section two-a, article fifteen (definitions); section two-b,  
45 article fifteen (guaranteed issue); section two-d, article  
46 fifteen (exception to guaranteed renewability); section  
47 two-e, article fifteen (discontinuation of coverage); section  
48 two-f, article fifteen (certification of creditable coverage);  
49 section two-g, article fifteen (applicability); section four-e,  
50 article fifteen (benefits for mothers and newborns); section  
51 fourteen, article fifteen (individual accident and sickness  
52 insurance); section sixteen, article fifteen (coverage of  
53 children); section eighteen, article fifteen (equal treatment  
54 of state agency); section nineteen, article fifteen  
55 (coordination of benefits with medicaid); article fifteen-b  
56 (uniform health care administration act); article fifteen-c  
57 (diabetes insurance); section three, article sixteen (required  
58 policy provisions); section three-a, article sixteen (mental  
59 health); section three-f, article sixteen (treatment of  
60 temporomandibular disorder and craniomandibular  
61 disorder); section three-j, article sixteen (benefits for  
62 mothers and newborns); section three-k, article sixteen  
63 (preexisting condition exclusions); section three-l, article  
64 sixteen (guaranteed renewability); section three-m, article  
65 sixteen (creditable coverage); section three-n, article  
66 (eligibility for enrollment); section eleven, article sixteen  
67 (coverage of children); section thirteen, article sixteen  
68 (equal treatment of state agency); section fourteen, article  
69 sixteen (coordination of benefits with medicaid); section  
70 sixteen, article sixteen (diabetes insurance); article  
71 sixteen-a (group health insurance conversion); article  
72 sixteen-c (small employer group policies); article  
73 sixteen-d (marketing and rate practices for small  
74 employers); article twenty-seven (insurance holding

75 company systems); article thirty-four-a (standards and  
76 commissioner's authority for companies deemed to be in  
77 hazardous financial condition); article thirty-five (criminal  
78 sanctions for failure to report impairment); article  
79 thirty-seven (managing general agents); and article  
80 thirty-nine (disclosure of material transactions); and article  
81 forty-one (privileges and immunity) shall be applicable to  
82 any health maintenance organization granted a certificate  
83 of authority under this article. In circumstances where the  
84 code provisions made applicable to health maintenance  
85 organizations by this section refer to the "insurer", the  
86 "corporation" or words of similar import, the language  
87 shall be construed to include health maintenance  
88 organizations.

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

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

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

*Russ Schowen*  
Chairman Senate Committee

*Nick Frantasia*  
Chairman House Committee

Originating in the House.

Takes effect from passage.

*Darrell E. Robles*  
Clerk of the Senate

*Bryony M. Bray*  
Clerk of the House of Delegates

*Carl Ray Tomblin*  
President of the Senate

*Timothy W. Wainwright*  
Speaker of the House of Delegates

The within *is approved* this the *7<sup>th</sup>*  
day of *May*, 1997.

*Jeffrey D. Underwood*  
Governor



PRESENTED TO THE

GOVERNOR

Date 4/29/97

Time 3:00 pm