COMMITTEE SUBSTITUTE

for

H. B. 2728

(BY DELEGATE(S) MCCUSKEY AND WESTFALL)

(Originating in the House Committee on Finance.)

[February 26, 2015]

A BILL to amend and reenact §33-24-4 of the Code of West Virginia, 1931, as amended; to amend and reenact §33-25-6 of said code; to amend and reenact §33-25A-24 of said code; to amend and reenact §33-25D-26 of said code; to amend and reenact §33-40-1, §33-40-2, §33-40-3, §33-40-6 and §33-40-7 of said code; and to amend said code by adding thereto a new article, designated §33-40A-1, §33-40A-2, §33-40A-3, §33-40A-4, §33-40A-5, §33-40A-6, §33-40A-7, §33-40A-8, §33-40A-9, §33-40A-10,

§33-40A-11 and §33-40A-12, all relating to risk-based capital reporting for health organizations; making health organizations subject to the statutory provisions concerning risk-based capital reporting; defining terms associated with risk-based capital reporting for health organizations; requiring a domestic health organization to file a risk-based capital report with the Insurance Commissioner; requiring a health organization to perform certain actions if the risk-based capital report indicates a negative financial trend or hazardous financial condition; requiring the Insurance Commissioner to conduct certain actions if the risk-based capital report of a health organization indicates a negative financial trend or hazardous financial condition; providing a health organization a right to a confidential hearing with respect to its risk-based capital report; making risk-based capital reports confidential; prohibiting the use of risk-based capital reports in the rate-making of a health organization; granting the Insurance Commissioner the authority to promulgate rules; requiring a foreign health organization to file a risk-based capital report with the Insurance Commissioner; and providing immunity to the Insurance Commissioner and his employees or agents for

actions taken with respect to monitoring the financial stability of a health organization.

Be it enacted by the Legislature of West Virginia:

That §33-24-4 of the Code of West Virginia, 1931, as amended, be amended and reenacted; that §33-25-6 of said code be amended and reenacted; that §33-25A-24 of said code be amended and reenacted; that §33-25D-26 of said code be amended and reenacted; that §33-40-1, §33-40-2, §33-40-3, §33-40-6 and §33-40-7 of said code be amended and reenacted; and that said code be amended by adding thereto a new article, designated §33-40A-1, §33-40A-2, §33-40A-3, §33-40A-4, §33-40A-5, §33-40A-6, §33-40A-7, §33-40A-8, §33-40A-9, §33-40A-10, §33-40A-11 and §33-40A-12, all to read as follows:

ARTICLE 24. HOSPITAL MEDICAL AND DENTAL CORPORATIONS.

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

Every corporation defined in section two of this article is hereby declared to be a scientific, nonprofit institution and exempt from the payment of all property and other taxes. Every corporation, to the same extent the provisions are applicable to insurers transacting similar kinds of insurance and not

inconsistent with the provisions of this article, shall be governed by and be subject to the provisions as herein below indicated, of the following articles of this chapter: Article two (Insurance Commissioner); article four (general provisions), except that section sixteen of said article may not be applicable thereto; section twenty, article five (borrowing by insurers); section thirty-four, article six (fee for form, rate and rule filing); article six-c (guaranteed loss ratios as applied to individual sickness and accident insurance policies); article seven (assets and liabilities); article eight-a (use of clearing corporations and federal reserve book-entry system); article eleven (unfair trade practices); article twelve (insurance producers and solicitors), except that the agent's license fee shall be twenty-five dollars; section two-a, article fifteen (definitions); section two-b, article fifteen (guaranteed issue; limitation of coverage; election; denial of coverage; network plans); section two-d, article fifteen (exceptions to guaranteed renewability); section two-e, article fifteen (discontinuation of particular type of coverage; uniform termination of all coverage; uniform modification of coverage); section two-f, article fifteen (certification of creditable

coverage); section two-g, article fifteen (applicability); section four-e, article fifteen (benefits for mothers and newborns); section fourteen, article fifteen (policies discriminating among health care providers); section sixteen, article fifteen (policies not to exclude insured's children from coverage; required services; coordination with other insurance); section eighteen, article fifteen (equal treatment of state agency); section nineteen, article fifteen (coordination of benefits with medicaid); article fifteen-a (West Virginia Long-Term Care Insurance Act); article fifteen-c (diabetes insurance); section three, article sixteen (required policy provisions); section three-a, article sixteen (same - mental health); section three-d, article sixteen (medicare supplement insurance); section three-f, article sixteen (required policy provisions - treatment of temporomandibular joint disorder and craniomandibular disorder); section three-j, article sixteen (hospital benefits for mothers and newborns); section three-k, article sixteen (limitations on preexisting condition exclusions for health benefit plans); section three-l, article sixteen (renewability and modification of health benefit plans); section three-m, article sixteen (creditable coverage); section

three-n, article sixteen (eligibility for enrollment); section eleven, article sixteen (group policies not to exclude insured's children from coverage; required services; coordination with other insurance); section thirteen, article sixteen (equal treatment of state agency); section fourteen, article sixteen (coordination of benefits with medicaid); section sixteen, article sixteen (insurance for diabetics); article sixteen-a (group health insurance conversion); article sixteen-c (employer group accident and sickness insurance policies); article sixteen-d (marketing and rate practices for small employer accident and sickness insurance policies); article twenty-six-a (West Virginia Life and Health Insurance Guaranty Association Act), after October 1, 1991, article twenty-seven (insurance holding company systems); article twenty-eight (individual accident and sickness insurance minimum standards); article thirty-three (annual audited financial report); article thirty-four (administrative supervision); article thirty-four-a (standards and commissioner's authority for companies ~~deemed~~ considered to be in hazardous financial condition); article thirty-five (criminal sanctions for failure to report impairment); article thirty-seven

(managing general agents); article forty-a (risk-based capital for health organizations); and article forty-one (Insurance Fraud Prevention Act) and no other provision of this chapter may apply to these corporations unless specifically made applicable by the provisions of this article. If, however, the corporation is converted into a corporation organized for a pecuniary profit or if it transacts business without having obtained a license as required by section five of this article, it shall thereupon forfeit its right to these exemptions.

ARTICLE 25. HEALTH CARE CORPORATIONS.

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

Corporations organized under this article are subject to supervision and regulation of the Insurance Commissioner. The corporations organized under this article, to the same extent these provisions are applicable to insurers transacting similar kinds of insurance and not inconsistent with the provisions of this article, shall be governed by and be subject to the provisions as herein below indicated of the following articles of this chapter: Article four (general provisions), except that section

sixteen of said article shall not be applicable thereto; article six-c (guaranteed loss ratio); article seven (assets and liabilities); article eight (investments); article ten (rehabilitation and liquidation); section two-a, article fifteen (definitions); section two-b, article fifteen (guaranteed issue); section two-d, article fifteen (exception to guaranteed renewability); section two-e, article fifteen (discontinuation of coverage); section two-f, article fifteen (certification of creditable coverage); section two-g, article fifteen (applicability); section four-e, article fifteen (benefits for mothers and newborns); section fourteen, article fifteen (individual accident and sickness insurance); section sixteen, article fifteen (coverage of children); section eighteen, article fifteen (equal treatment of state agency); section nineteen, article fifteen (coordination of benefits with medicaid); article fifteen-c (diabetes insurance); section three, article sixteen (required policy provisions); section three-a, article sixteen (mental health); section three-j, article sixteen (benefits for mothers and newborns); section three-k, article sixteen (preexisting condition exclusions); section three-l, article sixteen (guaranteed renewability); section three-m, article sixteen

(creditable coverage); section three-n, article sixteen (eligibility for enrollment); section eleven, article sixteen (coverage of children); section thirteen, article sixteen (equal treatment of state agency); section fourteen, article sixteen (coordination of benefits with medicaid); section sixteen, article sixteen (diabetes insurance); article sixteen-a (group health insurance conversion); article sixteen-c (small employer group policies); article sixteen-d (marketing and rate practices for small employers); article twenty-five-f (coverage for patient cost of clinical trials); article twenty-six-a (West Virginia life and health insurance guaranty association act); article twenty-seven (insurance holding company systems); article thirty-three (annual audited financial report); article thirty-four-a (standards and commissioner's authority for companies ~~deemed~~ considered to be in hazardous financial condition); article thirty-five (criminal sanctions for failure to report impairment); article thirty-seven (managing general agents); article forty-a (risk-based capital for health organizations); and article forty-one (privileges and immunity); and no other provision of this chapter may apply to

these corporations unless specifically made applicable by the provisions of this article.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

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

(a) Except as otherwise provided in this article, provisions of the insurance laws and provisions of hospital or medical service corporation laws are not applicable to any health maintenance organization granted a certificate of authority under this article. The provisions of this article ~~shall~~ may not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this state except with respect to its health maintenance corporation activities authorized and regulated pursuant to this article. The provisions of this article may not apply to an entity properly licensed by a reciprocal state to provide health care services to employer groups, where residents of West Virginia are members of an employer group, and the employer group contract is entered into in the reciprocal state. For purposes of this subsection, a "reciprocal state" means a state which physically borders West Virginia and which has

subscriber or enrollee hold harmless requirements substantially similar to those set out in section seven-a of this article.

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

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

(d) The following provisions of this chapter ~~shall be~~ are applicable to any health maintenance organization granted a

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

policy provisions); section three-f, article sixteen (required policy provisions - treatment of temporomandibular joint disorder and craniomandibular disorder); section eleven, article sixteen (group policies not to exclude insured's children from coverage; required services; coordination with other insurance); section thirteen, article sixteen (equal treatment of state agency); section fourteen, article sixteen (coordination of benefits with Medicaid); article sixteen-a (group health insurance conversion); article sixteen-d (marketing and rate practices for small employer accident and sickness insurance policies); article twenty-five-c (Health Maintenance Organization Patient Bill of Rights); article twenty-five-f (coverage for patient cost of clinical trials); article twenty-seven (insurance holding company systems); article thirty-three (annual audited financial report); article thirty-four (administrative supervision); article thirty-four-a (standards and commissioner's authority for companies considered to be in hazardous financial condition); article thirty-five (criminal sanctions for failure to report impairment); article thirty-seven (managing general agents); article thirty-nine (disclosure of material transactions); ~~article~~

~~forty (risk-based capital for insurers);~~ article forty-a (risk-based capital for health organizations); article forty-one (Insurance Fraud Prevention Act); and article forty-two (Women's Access to Health Care Act). In circumstances where the code provisions made applicable to health maintenance organizations by this subsection refer to the "insurer", the "corporation" or words of similar import, the language shall be construed to include health maintenance organizations.

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

ARTICLE 25D. PREPAID LIMITED HEALTH SERVICE ORGANIZATION ACT.

§33-25D-26. Scope of provisions; applicability of other laws.

(a) Except as otherwise provided in this article, provisions of the insurance laws, provisions of hospital, medical, dental or health service corporation laws and provisions of health maintenance organization laws are not applicable to any prepaid limited health service organization granted a certificate of

authority under this article. The provisions of this article do not apply to an insurer, hospital, medical, dental or health service corporation, or health maintenance organization licensed and regulated pursuant to the insurance laws, hospital, medical, dental or health service corporation laws or health maintenance organization laws of this state except with respect to its prepaid limited health service corporation activities authorized and regulated pursuant to this article. The provisions of this article do not apply to an entity properly licensed by a reciprocal state to provide a limited health care service to employer groups, where residents of West Virginia are members of an employer group, and the employer group contract is entered into in the reciprocal state. For purposes of this subsection, a "reciprocal state" means a state which physically borders West Virginia and which has subscriber or enrollee hold harmless requirements substantially similar to those set out in section ten of this article.

(b) Factually accurate advertising or solicitation regarding the range of services provided, the premiums and copayments charged, the sites of services and hours of operation and any other quantifiable, nonprofessional aspects of its operation by a

prepaid limited health service organization granted a certificate of authority, or its representative do not violate any provision of law relating to solicitation or advertising by health professions: *Provided,* That nothing contained in this subsection authorizes any solicitation or advertising which identifies or refers to any individual provider or makes any qualitative judgment concerning any provider.

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

(d) The provisions of section nine, article two, examinations; section nine-a, article two, one-time assessment; section thirteen, article two, hearings; sections fifteen and twenty, article four, general provisions; section twenty, article five, borrowing by insurers; section seventeen, article six, noncomplying forms; article six-c, guaranteed loss ratio; article seven, assets and liabilities; article eight, investments; article eight-a, use of clearing corporations and federal reserve book-entry system; article nine, administration of deposits; article ten, rehabilitation

and liquidation; article twelve, agents, brokers, solicitors and excess line; section fourteen, article fifteen, individual accident and sickness insurance; section sixteen, article fifteen, coverage of children; section eighteen, article fifteen, equal treatment of state agency; section nineteen, article fifteen, coordination of benefits with medicaid; article fifteen-b, uniform health care administration act; section three, article sixteen, required policy provisions; section eleven, article sixteen, coverage of children; section thirteen, article sixteen, equal treatment of state agency; section fourteen, article sixteen, coordination of benefits with medicaid; article sixteen-a, group health insurance conversion; article sixteen-d, marketing and rate practices for small employers; article twenty-seven, insurance holding company systems; article thirty-three, annual audited financial report; article thirty-four, administrative supervision; article thirty-four-a, standards and commissioner's authority for companies considered to be in hazardous financial condition; article thirty-five, criminal sanctions for failure to report impairment; article thirty-seven, managing general agents; article thirty-nine, disclosure of material transactions; article

forty-a, risk-based capital for health organizations; and article forty-one, privileges and immunity, all of this chapter are applicable to any prepaid limited health service organization granted a certificate of authority under this article. In circumstances where the code provisions made applicable to prepaid limited health service organizations by this section refer to the "insurer", the "corporation" or words of similar import, the language includes prepaid limited health service organizations.

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

(f) A prepaid limited health service organization granted a certificate of authority under this article is exempt from paying municipal business and occupation taxes on gross income it receives from its enrollees, or from their employers or others on their behalf, for health care items or services provided directly or indirectly by the prepaid limited health service organization.

ARTICLE 40. RISK-BASED CAPITAL FOR INSURERS.

§33-40-1. Definitions.

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

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

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

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

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

~~(e)~~ (d) "Foreign insurer" means any insurance company which is licensed to do business in this state under article three of this chapter but is not domiciled in this state. ~~or any HMO that~~

~~has been issued a certificate of authority under article twenty-five-a of this chapter but that is not domiciled in this state.~~

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

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

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

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

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

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

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

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

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

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

~~(l)~~ (k) "RBC plan" means a comprehensive financial plan containing the elements specified in subsection (b), section three of this article. If the commissioner rejects the RBC plan and it is revised by the insurer ~~or HMO~~, with or without the

commissioner's recommendation, the plan shall be called the revised RBC plan.

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

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

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

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

§33-40-2. RBC reports.

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

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

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

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

(B) The filing date.

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

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

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

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

(4) All other business risks and any other relevant risks set forth in the RBC instructions determined in each case by

applying the factors in the manner set forth in the RBC instructions.

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

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

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

(d) An excess of capital over the amount produced by the risk-based capital requirements contained in this article and the formulas, schedules and instructions referenced in this article is desirable in the business of insurance. Accordingly, insurers ~~and HMOs~~ should seek to maintain capital above the RBC levels required by this article. Additional capital is used and useful in the insurance business and helps to secure insurers ~~and HMOs~~

against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this article.

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

§33-40-3. Company action level event.

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

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

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

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

control level RBC and two and one-half and has a negative trend; or

(C) If a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its company action level RBC, but less than the product of its authorized control level RBC and three and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty RBC instructions;

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

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

(b) ~~In the event of~~ If there is a company action level event, the insurer shall prepare and submit to the commissioner an RBC plan which shall:

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

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

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

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

(5) Identify the quality of, and problems associated with, the insurer's business, including, but not limited to, its assets,

anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(c) The RBC plan shall be submitted:

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

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

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

by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(1) Within forty-five days after the notification from the commissioner; or

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

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

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

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

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

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

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

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

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

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

(2) Notification by the commissioner to the insurer ~~or HMO~~ of an adjusted RBC report that indicates the event in subdivision (1) of this subsection, provided the insurer ~~or HMO~~ does not

challenge the adjusted RBC report under section seven of this article; or

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

(b) ~~In the event of~~ If there is a mandatory control level event:

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

commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.

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

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

§33-40-7. Hearings.

Insurers have the right to a confidential departmental hearing, on the record, at which the insurer may challenge any determination or action by the commissioner made pursuant to

the provisions of this article. The insurer shall notify the commissioner of its request for a hearing within ten days after receiving notification from the commissioner.

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

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

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

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

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

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

(e) Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing, which shall be no

less than fifteen nor more than forty-five days after the date of the insurer's request.

~~(f) To the extent that the provisions of this section conflict with any other provisions applicable to HMOs, the provisions of this section apply.~~

ARTICLE 40A. RISKED-BASED CAPITAL FOR HEALTH ORGANIZATIONS.

§33-40A-1. Definitions.

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

(a) "Adjusted RBC report" means an RBC report which has been adjusted by the commissioner in accordance with subsection (d), section two of this article.

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

(c) "Domestic health organization" means a health organization domiciled in this state.

(d) "Foreign health organization" means a health organization that is licensed to do business in this state under

article twenty-five-a of this chapter but is not domiciled in this state.

(e) "Health organization" means a health maintenance organization licensed under article twenty-five-a of this chapter, limited health service organization licensed under article twenty-five-d of this chapter, provider sponsored network licensed under article twenty-five-g of this chapter, hospital, medical and dental indemnity or service corporation licensed under article twenty-four of this chapter or other managed care organization licensed under article twenty-five of this chapter. This definition does not include an organization that is licensed under article three of this chapter as either a life or health insurer or a property and casualty insurer and that is otherwise subject to either the life and health or property and casualty RBC requirements.

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

(g) "Negative trend" means a negative trend over a period of time, as determined in accordance with the trend test calculation included in the RBC instructions.

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

(i) "RBC level" means a health organization's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(1) "Company action level RBC" means, with respect to any health organization, the product of 2.0 and its authorized control level RBC;

(2) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC;

(3) "Authorized Control Level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(4) "Mandatory Control Level RBC" means the product of .70 and the authorized control level RBC.

(j) "RBC plan" means a comprehensive financial plan containing the elements specified in subsection (b), section three of this article. If the commissioner rejects the RBC plan, and it

is revised by the health organization, with or without the commissioner's recommendation, the plan shall be called the "revised RBC plan."

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

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

(1) A health organization's statutory capital and surplus (i.e. net worth) as determined in accordance with the statutory accounting application to the annual financial statements required to be filed under:

(A) Section four, article twenty-four of this chapter;

(B) Section nine, article twenty-five of this chapter;

(C) Section nine, article twenty-five-a of this chapter; or

(D) Section twelve, article twenty-five-d of this chapter; and

(2) Such other items, if any, as the RBC instructions may provide.

§33-40A-2. RBC reports.

(a) A domestic health organization, on or prior to each March 1 (the "filing date"), shall prepare and submit to the commissioner a report of its RBC levels as of the end of the

calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, a domestic health organization shall file its RBC report:

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

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

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

(B) The filing date.

(b) A health organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account (and may adjust for the covariance between) determined in each case by applying the factors in the manner set forth in the RBC instructions.

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

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

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

(d) If a domestic health organization files an RBC report that in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the health organization of the adjustment. The notice shall contain a statement of the reason for

the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report."

§33-40A-3. Company action level event.

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

(1) The filing of an RBC report by a health organization that indicates that the health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(2) If a health organization has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the health RBC instructions:

(3) Notification by the commissioner to the health organization of an adjusted RBC report that indicates an event in subdivision (1) of this subsection, provided the health organization does not challenge the adjusted RBC report under section seven of this article; or

(4) If, pursuant to section seven of this article, a health organization challenges an adjusted RBC report that indicates the event in subdivision (1) of this subsection, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

(b) If there is a company action level event, the health organization shall prepare and submit to the commissioner an RBC plan that shall:

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

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

(3) Provide projections of the health organization's financial results in the current year and at least two succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and

renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

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

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

(c) The RBC plan shall be submitted:

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

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

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

(1) Within forty-five days after the notification from the commissioner; or

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

(e) If there is a notification by the commissioner to a health organization that the health organization's RBC plan or revised RBC plan is unsatisfactory, the commissioner may, subject to the health organization's right to a hearing under section seven of this article, specify in the notification that the notification constitutes a regulatory action level event.

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

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

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

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

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

§33-40A-4. Regulatory action level event.

(a) "Regulatory action level event" means, with respect to a health organization, any of the following events:

(1) Filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(2) Notification by the commissioner to a health organization of an adjusted RBC report that indicates the event in subdivision (1) of this subsection, provided the health organization does not challenge the adjusted RBC report under section seven of this article;

(3) If, pursuant to section seven of this article, the health organization challenges an adjusted RBC report that indicates the event in subdivision (1) of this subsection, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge;

(4) The failure of the health organization to file an RBC report by the filing date, unless the health organization has provided an explanation for the failure that is satisfactory to the commissioner and has cured the failure within ten days after the filing date;

(5) The failure of the health organization to submit an RBC plan to the commissioner within the time period set forth in subsection (c), section three of this article;

(6) Notification by the commissioner to the health organization that:

(A) The RBC plan or revised RBC plan submitted by the health organization is, in the judgment of the commissioner, unsatisfactory; and

(B) Notification constitutes a regulatory action level event with respect to the health organization, provided the health organization has not challenged the determination under section seven of this article;

(7) If, pursuant to section seven of this article, the health organization challenges a determination by the commissioner under subdivision (6) of this subsection, the notification by the

commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge;

(8) Notification by the commissioner to the health organization that the health organization has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification, provided the health organization has not challenged the determination under section seven of this article; or

(9) If, pursuant to section seven of this article, the health organization challenges a determination by the commissioner under subdivision (8) of this subsection, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge.

(b) If there is a regulatory action level event, the commissioner shall:

(1) Require the health organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(2) Perform such examination or analysis as the commissioner considers necessary of the assets, liabilities and operations of the health organization including a review of its RBC plan or revised RBC plan; and

(3) Subsequent to the examination or analysis, issue an order specifying such corrective actions as the commissioner determine are required (a "corrective order").

(c) In determining corrective actions, the commissioner may take into account factors the commissioner deems relevant with respect to the health organization based upon the commissioner's examination or analysis of the assets, liabilities and operations of the health organization, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(1) Within forty-five days after the occurrence of the regulatory action level event;

(2) If the health organization challenges an adjusted RBC report pursuant to section seven of this article and the challenge is not frivolous in the judgment of the commissioner, within

forty-five days after the notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge; or

(3) If the health organization challenges a revised RBC plan pursuant to section seven of this article and the challenge is not frivolous in the judgment of the commissioner, within forty-five days after the notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

(d) The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the health organization's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations (including contractual relationships) of the health organization and formulate the corrective order with respect to the health organization. The fees, costs and expenses relating to consultants shall be borne by the affected health organization or such other party as directed by the commissioner.

§33-40A-5. Authorized control level event.

(a) "Authorized control level event" means any of the following events:

(1) The filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(2) The notification by the commissioner to the health organization of an adjusted RBC report that indicates the event in subdivision (1) of this subsection, if the health organization does not challenge the adjusted RBC report under section seven of this article;

(3) If, pursuant to section seven of this article, the health organization challenges an adjusted RBC report that indicates the event in subdivision (1) of this subsection, notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge;

(4) The failure of the health organization to respond, in a manner satisfactory to the commissioner, to a corrective order,

if the health organization has not challenged the corrective order under section seven of this article; or

(5) If the health organization has challenged a corrective order under section seven of this article and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health organization to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(b) If there is an authorized control level event with respect to a health organization, the commissioner shall:

(1) Take such actions as are required under section four of this article regarding a health organization with respect to which a regulatory action level event has occurred; or

(2) If the commissioner considers it to be in the best interests of the policyholders and creditors of the health organization and of the public, take such actions as are necessary to cause the health organization to be placed under regulatory control under article ten of this chapter. If the commissioner takes such actions, the authorized control level event shall be considered

sufficient grounds for the commissioner to take action under article ten of this chapter, and the commissioner has the rights, powers and duties with respect to the health organization as are set forth in article ten of this chapter. If the commissioner takes actions under this subdivision pursuant to an adjusted RBC report, the health organization is entitled to such protections as are afforded to health organizations under the provisions of section four-b, article ten of this chapter pertaining to summary proceedings.

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

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

(1) The filing of an RBC report which indicates that the health organization's total adjusted capital is less than its mandatory control level RBC;

(2) Notification by the commissioner to the health organization of an adjusted RBC report that indicates the event in subdivision (1) of this subsection, if the health organization does not challenge the adjusted RBC report under section seven of this article; or

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

(b) If is a mandatory control level event, the commissioner shall take such actions as are necessary to place the health organization under regulatory control under article ten of this chapter. In that event, the mandatory control level event is sufficient grounds for the commissioner to take action under article ten of this chapter, and the commissioner has the rights, powers and duties with respect to the health organization as are set forth in article ten of this chapter. If the commissioner takes actions pursuant to an adjusted RBC report, the health organization is entitled to the protections of section four-b, article ten of this chapter pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable

expectation that the mandatory control level event may be eliminated within the ninety-day period.

§33-40A-7. Hearings.

Upon the occurrence of any of the following events the health organization has the right to a confidential departmental hearing, on a record, at which the health organization may challenge any determination or action by the commissioner. The health organization shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under subsections (a), (b), (c) or (d) of this section. Upon receipt of the health organization's request for a hearing, the commissioner shall set a date for the hearing, which shall be no less than ten nor more than thirty days after the date of the health organization's request. The events include:

(a) Notification to a health organization by the commissioner of an adjusted RBC report;

(b) Notification to a health organization by the commissioner that:

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

(2) Notification constitutes a regulatory action level event with respect to the health organization;

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

(d) Notification to a health organization by the commissioner of a corrective order with respect to the health organization.

§33-40A-8. Confidentiality; prohibition on announcements; prohibition on use in ratemaking.

(a) All RBC reports (to the extent the information is not required to be set forth in a publicly available annual statement schedule) and RBC plans (including the results or report of any examination or analysis of a health organization performed pursuant to this statute and any corrective order issued by the commissioner pursuant to examination or analysis) with respect to a domestic health organization or foreign health organization

that are in the possession or control of the commissioner shall be confidential by law and privileged, are not subject to the provisions of chapter twenty-nine-b of this code, are not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action. However, the commissioner may use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

(b) Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner are permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (a) of this section.

(c) In order to assist in the performance of the commissioner's duties, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (a) of this section, with other state, federal and international regulatory agencies, with

the NAIC and its affiliates and subsidiaries, and with state, federal and international law-enforcement authorities the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law-enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(3) May enter into agreements governing sharing and use of information consistent with this subsection.

(d) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information may occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subdivision (3), subsection (c) of this section.

(e) It is the finding of the Legislature that the comparison of a health organization's total adjusted capital to any of its RBC levels is a regulatory tool which may indicate the need for corrective action with respect to the health organization, and is not intended as a means to rank health organizations generally. Therefore, except as otherwise required under the provisions of this article, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over a radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any health organization, or of any component derived in the calculation by any health organization, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited*: Provided,* That if any materially false statement with respect to the comparison regarding a health organization's total adjusted capital to its

RBC levels (or any of them) or an inappropriate comparison of any other amount to the health organization's RBC levels is published in any written publication and the health organization is able to demonstrate to the commissioner with substantial proof the falsity of the statement, or the inappropriateness, as the case may be, then the health organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(f) It is the further finding of the Legislature that the RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of health organizations and the need for possible corrective action with respect to health organizations and shall not be used by the commissioner for rate making nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a health organization or any affiliate is authorized to write.

§33-40A-9. Supplemental provisions; rules; exemption.

(a) The provisions of this article are supplemental to any other provisions of the laws of this state, and do not preclude or limit any other powers or duties of the commissioner under such laws, including, but not limited to, article ten and article thirty-four of this chapter.

(b) The commissioner may propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code, as are necessary to effectuate the purposes of this article and to prevent circumvention and evasion thereof.

(c) The commissioner may exempt from the application of this article a domestic health organization that:

(1) Writes direct business only in this state;

(2) Assumes no reinsurance in excess of five percent of direct premiums written; and

(3) Writes direct annual premiums for comprehensive medical business of $2 million or less; or

(4) Is a limited health service organization that covers less than two thousand lives.

§33-40A-10. Foreign health organizations.

(a)(1) A foreign health organization, upon the written request of the commissioner, shall submit to the commissioner an RBC report, as of the end of the calendar year just ended, not later than the later of:

(A) The date an RBC report would be required to be filed by a domestic health organization under this article; or

(B) Fifteen days after the request is received by the foreign health organization.

(2) A foreign health organization, at the written request of the commissioner, shall promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(b) If there is a company action level event, regulatory action level event or authorized control level event with respect to a foreign health organization as determined under the RBC statute applicable in the state of domicile of the health organization (or, if no RBC statute is in force in that state, under the provisions this article), if the Insurance Commissioner of the state of domicile of the foreign health organization fails to require the

foreign health organization to file an RBC plan in the manner specified under that state's RBC statute (or, if no RBC statute is in force in that state, under section three of this article), the commissioner may require the foreign health organization to file an RBC plan with the commissioner. In that event, the failure of the foreign health organization to file an RBC plan with the commissioner is grounds to order the health organization to cease and desist from writing new insurance business in this state.

(c) If there is a mandatory control level event with respect to a foreign health organization, and no domiciliary receiver has been appointed with respect to the foreign health organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign health organization, the commissioner may make application to the Circuit Court of Kanawha County permitted under section two, article ten of this chapter with respect to the liquidation of property of foreign health organizations found in this state, and the occurrence of the mandatory control level even shall be considered adequate grounds for the application.

§33-40A-11. Immunity.

There is no liability on the part of, and no cause of action may arise against, the commissioner or the West Virginia Office of the Insurance Commissioner or its employees or agents for any action taken by them in the performance of their powers and duties under this article.

§33-40A-12. Notices.

All notices by the commissioner to a health organization that may result in regulatory action under this article are effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the health organization's receipt of notice.