

COMMITTEE SUBSTITUTE

for

**H. B. 2728**

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(BY DELEGATE(S) MCCUSKEY AND WESTFALL)

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(Originating in the House Committee on Finance.)

[February 26, 2015]

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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.**

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

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

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

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

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

**ARTICLE 25. HEALTH CARE CORPORATIONS.**

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

**ARTICLE 25D. PREPAID LIMITED HEALTH SERVICE ORGANIZATION  
ACT.**

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

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

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

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

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

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

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



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

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

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

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

**ARTICLE 40. RISK-BASED CAPITAL FOR INSURERS.**

**§33-40-1. Definitions.**

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

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

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

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

13 ~~(d)~~ (c) “Domestic insurer” means any insurance company or  
14 farmers’ mutual fire insurance company ~~or HMO~~ domiciled in  
15 this state.

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

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

22       ~~(f)~~ (e) “NAIC” means the National Association of Insurance  
23 Commissioners.

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

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

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

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

42       ~~(k)~~ (j) “RBC level” means an insurer’s ~~or HMO’s~~ company  
 43 action level RBC, regulatory action level RBC, authorized  
 44 control level RBC, or mandatory control level RBC where:

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

47       (2) “Regulatory action level RBC” means the product of one  
 48 and one-half and its authorized control level RBC;

49       (3) “Authorized control level RBC” means the number  
 50 determined under the risk-based capital formula in accordance  
 51 with the RBC instructions;

52       (4) “Mandatory control level RBC” means the product of  
 53 seven-tenths and the authorized control level RBC.

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

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

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

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

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

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

**§33-40-2. RBC reports.**

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

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

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

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

16       (B) The filing date.

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

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

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

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

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

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

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

- 36 (1) Asset risk;  
37 (2) Credit risk;  
38 (3) Underwriting risk; and  
39 (4) All other business risks and any other relevant risks as  
40 are set forth in the RBC instructions.

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

54 (c) The RBC plan shall be submitted:

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

56 or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

**§33-40-7. Hearings.**

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

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

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

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

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

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

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

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

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

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

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

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

**§33-40A-1. Definitions.**

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

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

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

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

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

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

15 (e) “Health organization” means a health maintenance  
16 organization licensed under article twenty-five-a of this chapter,  
17 limited health service organization licensed under article  
18 twenty-five-d of this chapter, provider sponsored network  
19 licensed under article twenty-five-g of this chapter, hospital,  
20 medical and dental indemnity or service corporation licensed  
21 under article twenty-four of this chapter or other managed care  
22 organization licensed under article twenty-five of this chapter.  
23 This definition does not include an organization that is licensed  
24 under article three of this chapter as either a life or health insurer  
25 or a property and casualty insurer and that is otherwise subject  
26 to either the life and health or property and casualty RBC  
27 requirements.

28 (f) “NAIC” means the National Association of Insurance  
29 Commissioners.

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

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

37 (i) “RBC level” means a health organization’s company  
38 action level RBC, regulatory action level RBC, authorized  
39 control level RBC, or mandatory control level RBC where:

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

43 (2) “Regulatory action level RBC” means the product of 1.5  
44 and its authorized control level RBC;

45 (3) “Authorized Control Level RBC” means the number  
46 determined under the risk-based capital formula in accordance  
47 with the RBC instructions;

48 (4) “Mandatory Control Level RBC” means the product of  
49 .70 and the authorized control level RBC.

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

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

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

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

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

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

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

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

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

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

**§33-40A-2. RBC reports.**

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

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

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

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

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

16 (B) The filing date.

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

23 (1) Asset risk;

24       (2) Credit risk;

25       (3) Underwriting risk; and

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

28       (c) An excess of capital (i.e. net worth) over the amount  
29 produced by the risk-based capital requirements contained in this  
30 article and the formulas, schedules and instructions referenced  
31 in this article is desirable in the business of health insurance.

32 Accordingly, health organizations should seek to maintain  
33 capital above the RBC levels required by this article. Additional  
34 capital is used and useful in the insurance business and helps to  
35 secure a health organization against various risks inherent in, or  
36 affecting, the business of insurance and not accounted for or only  
37 partially measured by the risk-based capital requirements  
38 contained in this article.

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



44 the adjustment. An RBC report as so adjusted is referred to as an  
45 “adjusted RBC report.”

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

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

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

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

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

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

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

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

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

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

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

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

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

48 (c) The RBC plan shall be submitted:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

1        (a) “Authorized control level event” means any of the  
2        following events:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**§33-40A-7. Hearings.**

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13       (1) Writes direct business only in this state;

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

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

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

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

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

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

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

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

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

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

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

**§33-40A-11. Immunity.**

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

**§33-40A-12. Notices.**

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