

WEST VIRGINIA LEGISLATURE

2016 REGULAR SESSION

Enrolled

Committee Substitute

for

Senate Bill 429

BY SENATORS ASHLEY AND GAUNCH, *original sponsors*

[Passed March 9, 2016; in effect 90 days from passage]

1 AN ACT to amend and reenact §33-24-4 of the Code of West Virginia, 1931, as amended; to
2 amend and reenact §33-25-6 of said code; to amend and reenact §33-25A-24 of said
3 code; to amend and reenact §33-25D-26 of said code; to amend and reenact §33-40-1,
4 §33-40-2, §33-40-3, §33-40-6 and §33-40-7 of said code; and to amend said code by
5 adding thereto a new article, designated §33-40A-1, §33-40A-2, §33-40A-3, §33-40A-4,
6 §33-40A-5, §33-40A-6, §33-40A-7, §33-40A-8, §33-40A-9, §33-40A-10, §33-40A-11 and
7 §33-40A-12, all relating to risk-based capital; making health organizations subject to
8 statutory provisions concerning risk-based capital reporting; defining terms associated
9 with risk-based capital reporting for health organizations; requiring health organizations to
10 file risk-based capital reports with Insurance Commissioner; requiring health organizations
11 to perform certain actions if risk-based capital report indicates a negative financial trend
12 or hazardous financial condition; requiring Insurance Commissioner to conduct certain
13 actions if risk-based capital report of a health organization indicates negative financial
14 trend or hazardous financial condition; providing health organization right to a confidential
15 hearing with respect to certain notifications; specifying confidential and privileged nature
16 of risk-based capital reports and plans and related matters; prohibiting use of risk-based
17 capital reports in ratemaking of a health organization; granting Insurance Commissioner
18 authority to propose rules for legislative approval; providing immunity to Insurance
19 Commissioner and his employees and agents for actions taken with respect to monitoring
20 the financial stability of a health organization; and changing the definition of “company
21 action level event” for a life and health insurer.

Be it enacted by the Legislature of West Virginia:

1 That §33-24-4 of the Code of West Virginia, 1931, as amended, be amended and
2 reenacted; that §33-25-6 of said code be amended and reenacted; that §33-25A-24 of said code
3 be amended and reenacted; that §33-25D-26 of said code be amended and reenacted; that §33-
4 40-1, §33-40-2, §33-40-3, §33-40-6 and §33-40-7 of said code be amended and reenacted; and

5 that said code be amended by adding thereto a new article, designated §33-40A-1, §33-40A-2,
6 §33-40A-3, §33-40A-4, §33-40A-5, §33-40A-6, §33-40A-7, §33-40A-8, §33-40A-9, §33-40A-10,
7 §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 hereby declared to be a scientific,
2 nonprofit institution and exempt from the payment of all property and other taxes. Every
3 corporation, to the same extent the provisions are applicable to insurers transacting similar kinds
4 of insurance and not inconsistent with the provisions of this article, shall be governed by and be
5 subject to the provisions as herein below indicated, of the following articles of this chapter: Article
6 two (Insurance Commissioner); article four (general provisions), except that section sixteen of
7 said article may not be applicable thereto; section twenty, article five (borrowing by insurers);
8 section thirty-four, article six (fee for form, rate and rule filing); article six-c (guaranteed loss ratios
9 as applied to individual sickness and accident insurance policies); article seven (assets and
10 liabilities); article eight-a (use of clearing corporations and Federal Reserve book-entry system);
11 article eleven (unfair trade practices); article twelve (insurance producers and solicitors), except
12 that the agent's license fee shall be \$25; section two-a, article fifteen (definitions); section two-b,
13 article fifteen (guaranteed issue; limitation of coverage; election; denial of coverage; network
14 plans); section two-d, article fifteen (exceptions to guaranteed renewability); section two-e, article
15 fifteen (discontinuation of particular type of coverage; uniform termination of all coverage; uniform
16 modification of coverage); section two-f, article fifteen (certification of creditable coverage);
17 section two-g, article fifteen (applicability); section four-e, article fifteen (benefits for mothers and
18 newborns); section fourteen, article fifteen (policies discriminating among health care providers);
19 section sixteen, article fifteen (policies not to exclude insured's children from coverage; required
20 services; coordination with other insurance); section eighteen, article fifteen (equal treatment of
21 state agency); section nineteen, article fifteen (coordination of benefits with Medicaid); article

22 fifteen-a (West Virginia Long-Term Care Insurance Act); article fifteen-c (diabetes insurance);
23 section three, article sixteen (required policy provisions); section three-a, article sixteen (same -
24 mental health); section three-d, article sixteen (Medicare supplement insurance); section three-f,
25 article sixteen (required policy provisions - treatment of temporomandibular joint disorder and
26 craniomandibular disorder); section three-j, article sixteen (hospital benefits for mothers and
27 newborns); section three-k, article sixteen (limitations on preexisting condition exclusions for
28 health benefit plans); section three-l, article sixteen (renewability and modification of health benefit
29 plans); section three-m, article sixteen (creditable coverage); section three-n, article sixteen
30 (eligibility for enrollment); section eleven, article sixteen (group policies not to exclude insured's
31 children from coverage; required services; coordination with other insurance); section thirteen,
32 article sixteen (equal treatment of state agency); section fourteen, article sixteen (coordination of
33 benefits with Medicaid); section sixteen, article sixteen (insurance for diabetics); article sixteen-a
34 (group health insurance conversion); article sixteen-c (employer group accident and sickness
35 insurance policies); article sixteen-d (marketing and rate practices for small employer accident
36 and sickness insurance policies); article twenty-six-a (West Virginia Life and Health Insurance
37 Guaranty Association Act), after October 1, 1991, article twenty-seven (insurance holding
38 company systems); article twenty-eight (individual accident and sickness insurance minimum
39 standards); article thirty-three (annual audited financial report); article thirty-four (administrative
40 supervision); article thirty-four-a (standards and commissioner's authority for companies
41 considered to be in hazardous financial condition); article thirty-five (criminal sanctions for failure
42 to report impairment); article thirty-seven (managing general agents); article forty-a (risk-based
43 capital for health organizations); and article forty-one (Insurance Fraud Prevention Act) and no
44 other provision of this chapter may apply to these corporations unless specifically made applicable
45 by the provisions of this article. If, however, the corporation is converted into a corporation
46 organized for a pecuniary profit or if it transacts business without having obtained a license as
47 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.

1 Corporations organized under this article are subject to supervision and regulation of the
2 Insurance Commissioner. The corporations organized under this article, to the same extent these
3 provisions are applicable to insurers transacting similar kinds of insurance and not inconsistent
4 with the provisions of this article, shall be governed by and be subject to the provisions as herein
5 below indicated of the following articles of this chapter: Article four (general provisions), except
6 that section sixteen of said article shall not be applicable thereto; article six-c (guaranteed loss
7 ratio); article seven (assets and liabilities); article eight (investments); article ten (rehabilitation
8 and liquidation); section two-a, article fifteen (definitions); section two-b, article fifteen (guaranteed
9 issue); section two-d, article fifteen (exception to guaranteed renewability); section two-e, article
10 fifteen (discontinuation of coverage); section two-f, article fifteen (certification of creditable
11 coverage); section two-g, article fifteen (applicability); section four-e, article fifteen (benefits for
12 mothers and newborns); section fourteen, article fifteen (individual accident and sickness
13 insurance); section sixteen, article fifteen (coverage of children); section eighteen, article fifteen
14 (equal treatment of state agency); section nineteen, article fifteen (coordination of benefits with
15 Medicaid); article fifteen-c (diabetes insurance); section three, article sixteen (required policy
16 provisions); section three-a, article sixteen (mental health); section three-j, article sixteen (benefits
17 for mothers and newborns); section three-k, article sixteen (preexisting condition exclusions);
18 section three-l, article sixteen (guaranteed renewability); section three-m, article sixteen
19 (creditable coverage); section three-n, article sixteen (eligibility for enrollment); section eleven,
20 article sixteen (coverage of children); section thirteen, article sixteen (equal treatment of state
21 agency); section fourteen, article sixteen (coordination of benefits with Medicaid); section sixteen,
22 article sixteen (diabetes insurance); article sixteen-a (group health insurance conversion); article
23 sixteen-c (small employer group policies); article sixteen-d (marketing and rate practices for small

24 employers); article twenty-five-f (coverage for patient cost of clinical trials); article twenty-six-a
25 (West Virginia Life and Health Insurance Guaranty Association Act); article twenty-seven
26 (insurance holding company systems); article thirty-three (annual audited financial report); article
27 thirty-four-a (standards and commissioner's authority for companies considered to be in
28 hazardous financial condition); article thirty-five (criminal sanctions for failure to report
29 impairment); article thirty-seven (managing general agents); article forty-a (risk-based capital for
30 health organizations); and article forty-one (privileges and immunity); and no other provision of
31 this chapter may apply to these corporations unless specifically made applicable by the provisions
32 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 of the insurance laws and
2 provisions of hospital or medical service corporation laws are not applicable to any health
3 maintenance organization granted a certificate of authority under this article. The provisions of
4 this article shall not apply to an insurer or hospital or medical service corporation licensed and
5 regulated pursuant to the insurance laws or the hospital or medical service corporation laws of
6 this state except with respect to its health maintenance corporation activities authorized and
7 regulated pursuant to this article. The provisions of this article may not apply to an entity properly
8 licensed by a reciprocal state to provide health care services to employer groups, where residents
9 of West Virginia are members of an employer group, and the employer group contract is entered
10 into in the reciprocal state. For purposes of this subsection, a "reciprocal state" means a state
11 which physically borders West Virginia and which has subscriber or enrollee hold harmless
12 requirements substantially similar to those set out in section seven-a of this article.

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

16 granted a certificate of authority or its representative may not be construed to violate any provision
17 of law relating to solicitation or advertising by health professions: *Provided*, That nothing
18 contained in this subsection shall be construed as authorizing any solicitation or advertising which
19 identifies or refers to any individual provider or makes any qualitative judgment concerning any
20 provider.

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

24 (d) The following provisions of this chapter are applicable to any health maintenance
25 organization granted a certificate of authority under this article or which is otherwise subject to
26 the provisions of this article: The provisions of sections four, five, six, seven, eight, nine and nine-
27 a, article two (Insurance Commissioner); sections fifteen and twenty, article four (general
28 provisions); section twenty, article five (borrowing by insurers); section seventeen, article six
29 (validity of noncomplying forms); article six-c (guaranteed loss ratios as applied to individual
30 sickness and accident insurance policies); article seven (assets and liabilities); article eight
31 (investments); article eight-a (use of clearing corporations and federal reserve book-entry
32 system); article nine (administration of deposits); article ten (rehabilitation and liquidation); article
33 twelve (insurance producers and solicitors); section fourteen, article fifteen (policies discriminating
34 among health care providers); section sixteen, article fifteen (policies not to exclude insured's
35 children from coverage; required services; coordination with other insurance); section eighteen,
36 article fifteen (equal treatment of state agency); section nineteen, article fifteen (coordination of
37 benefits with Medicaid); article fifteen-b (Uniform Health Care Administration Act); section three,
38 article sixteen (required policy provisions); section three-f, article sixteen (required policy
39 provisions - treatment of temporomandibular joint disorder and craniomandibular disorder);
40 section eleven, article sixteen (group policies not to exclude insured's children from coverage;
41 required services; coordination with other insurance); section thirteen, article sixteen (equal

42 treatment of state agency); section fourteen, article sixteen (coordination of benefits with
43 Medicaid); article sixteen-a (group health insurance conversion); article sixteen-d (marketing and
44 rate practices for small employer accident and sickness insurance policies); article twenty-five-c
45 (Health Maintenance Organization Patient Bill of Rights); article twenty-five-f (coverage for patient
46 cost of clinical trials); article twenty-seven (insurance holding company systems); article thirty-
47 three (annual audited financial report); article thirty-four (administrative supervision); article thirty-
48 four-a (standards and commissioner's authority for companies considered to be in hazardous
49 financial condition); article thirty-five (criminal sanctions for failure to report impairment); article
50 thirty-seven (managing general agents); article thirty-nine (disclosure of material transactions);
51 article forty-a (risk-based capital for health organizations); article forty-one (Insurance Fraud
52 Prevention Act); and article forty-two (Women's Access to Health Care Act). In circumstances
53 where the code provisions made applicable to health maintenance organizations by this
54 subsection refer to the insurer, the corporation or words of similar import, the language shall be
55 construed to include health maintenance organizations.

56 (e) Any long-term care insurance policy delivered or issued for delivery in this state by a
57 health maintenance organization shall comply with the provisions of article fifteen-a of this
58 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 of the insurance laws,
2 provisions of hospital, medical, dental or health service corporation laws and provisions of health
3 maintenance organization laws are not applicable to any prepaid limited health service
4 organization granted a certificate of authority under this article. The provisions of this article do
5 not apply to an insurer, hospital, medical, dental or health service corporation, or health
6 maintenance organization licensed and regulated pursuant to the insurance laws, hospital,
7 medical, dental or health service corporation laws or health maintenance organization laws of this

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

15 (b) Factually accurate advertising or solicitation regarding the range of services provided,
16 the premiums and copayments charged, the sites of services and hours of operation and any
17 other quantifiable, nonprofessional aspects of its operation by a prepaid limited health service
18 organization granted a certificate of authority, or its representative do not violate any provision of
19 law relating to solicitation or advertising by health professions: *Provided*, That nothing contained
20 in this subsection authorizes any solicitation or advertising which identifies or refers to any
21 individual provider or makes any qualitative judgment concerning any provider.

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

25 (d) The provisions of section nine, article two, examinations; section nine-a, article two,
26 one-time assessment; section thirteen, article two, hearings; sections fifteen and twenty, article
27 four, general provisions; section twenty, article five, borrowing by insurers; section seventeen,
28 article six, noncomplying forms; article six-c, guaranteed loss ratio; article seven, assets and
29 liabilities; article eight, investments; article eight-a, use of clearing corporations and Federal
30 Reserve book-entry system; article nine, administration of deposits; article ten, rehabilitation and
31 liquidation; article twelve, agents, brokers, solicitors and excess line; section fourteen, article
32 fifteen, individual accident and sickness insurance; section sixteen, article fifteen, coverage of
33 children; section eighteen, article fifteen, equal treatment of state agency; section nineteen, article

34 fifteen, coordination of benefits with Medicaid; article fifteen-b, Uniform Health Care
35 Administration Act; section three, article sixteen, required policy provisions; section eleven, article
36 sixteen, coverage of children; section thirteen, article sixteen, equal treatment of state agency;
37 section fourteen, article sixteen, coordination of benefits with Medicaid; article sixteen-a, group
38 health insurance conversion; article sixteen-d, marketing and rate practices for small employers;
39 article twenty-seven, insurance holding company systems; article thirty-three, annual audited
40 financial report; article thirty-four, administrative supervision; article thirty-four-a, standards and
41 commissioner's authority for companies considered to be in hazardous financial condition; article
42 thirty-five, criminal sanctions for failure to report impairment; article thirty-seven, managing
43 general agents; article thirty-nine, disclosure of material transactions; article forty-a, risk-based
44 capital for health organizations; and article forty-one, privileges and immunity, all of this chapter
45 are applicable to any prepaid limited health service organization granted a certificate of authority
46 under this article. In circumstances where the code provisions made applicable to prepaid limited
47 health service organizations by this section refer to the insurer, the corporation or words of similar
48 import, the language includes prepaid limited health service organizations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§33-40-2. RBC reports.

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

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

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

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

10 (B) The filing date.

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

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

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

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

18 (4) All other business risks and any other relevant risks set forth in the RBC instructions
19 determined in each case by applying the factors in the manner set forth in the RBC instructions.

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

24 (1) Asset risk;

25 (2) Credit risk;

26 (3) Underwriting risk; and

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

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

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

§33-40-3. Company action level event.

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

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

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

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

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

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

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

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

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

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

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

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

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

35 (c) The RBC plan shall be submitted:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 (b) If there is a mandatory control level event:

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

22 (2) With respect to a property and casualty insurer, the commissioner shall take any
23 actions that are necessary to place the insurer under regulatory control under article ten of this
24 chapter or, in the case of an insurer which is writing no business and which is running-off its
25 existing business, may allow the insurer to continue its run-off under the supervision of the
26 commissioner. In either event, the mandatory control level event shall be considered sufficient
27 grounds for the commissioner to take action under said article and the commissioner has the
28 rights, powers and duties with respect to the insurer that are set forth in said article. If the
29 commissioner takes actions pursuant to an adjusted RBC report, the insurer is entitled to the

30 protections of said article pertaining to summary proceedings. Notwithstanding any of the
31 provisions of this subdivision, the commissioner may forego action for up to ninety days after the
32 mandatory control level event if the commissioner finds there is a reasonable expectation that the
33 mandatory control level event may be eliminated within the ninety-day period.

§33-40-7. Hearings.

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

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

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

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

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

9 or

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

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

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

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

§33-40A-1. Definitions.

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

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

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

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

7 (d) "Foreign health organization" means a health organization that is licensed to do
8 business in this state under article twenty-five-a of this chapter but is not domiciled in this state.

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

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

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

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

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

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

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

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

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

33 (j) "RBC plan" means a comprehensive financial plan containing the elements specified in
34 subsection (b), section three of this article. If the commissioner rejects the RBC plan, and it is
35 revised by the health organization, with or without the commissioner's recommendation, the plan
36 shall be called the "revised RBC plan".

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

38 (l) "Total adjusted capital" means the sum of:

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

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

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

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

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

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

§33-40A-2. RBC reports.

1 (a) A domestic health organization, on or prior to each March 1 (the filing date), shall
2 prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar
3 year just ended, in a form and containing such information as is required by the RBC instructions.

4 In addition, a domestic health organization shall file its RBC report:

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

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

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

11 (B) The filing date.

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

16 (1) Asset risk;

17 (2) Credit risk;

18 (3) Underwriting risk; and

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

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

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

31 statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an
32 adjusted RBC report.

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

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

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

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

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

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

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

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

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

21 (3) Provide projections of the health organization's financial results in the current year and
22 at least two succeeding years, both in the absence of proposed corrective actions and giving
23 effect to the proposed corrective actions, including projections of statutory balance sheets,

24 operating income, net income, capital and surplus, and RBC levels. The projections for both new
25 and renewal business might include separate projections for each major line of business and
26 separately identify each significant income, expense and benefit component;

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

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

33 (c) The RBC plan shall be submitted:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 (7) If, pursuant to section seven of this article, the health organization challenges a
25 determination by the commissioner under subdivision (6) of this subsection, the notification by the
26 commissioner to the health organization that the commissioner has, after a hearing, rejected the
27 challenge;

28 (8) Notification by the commissioner to the health organization that the health organization
29 has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial
30 adverse effect on the ability of the health organization to eliminate the company action level event
31 in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the

32 notification, provided the health organization has not challenged the determination under section
33 seven of this article; or

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

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

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

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

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

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

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

52 (2) If the health organization challenges an adjusted RBC report pursuant to section seven
53 of this article and the challenge is not frivolous in the judgment of the commissioner, within forty-
54 five days after the notification to the health organization that the commissioner has, after a
55 hearing, rejected the health organization's challenge; or

56 (3) If the health organization challenges a revised RBC plan pursuant to section seven of
57 this article and the challenge is not frivolous in the judgment of the commissioner, within forty-five

58 days after the notification to the health organization that the commissioner has, after a hearing,
59 rejected the health organization's challenge.

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

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

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

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

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

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

12 (4) The failure of the health organization to respond, in a manner satisfactory to the
13 commissioner, to a corrective order, if the health organization has not challenged the corrective
14 order under section seven of this article; or

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

18 commissioner, to the corrective order subsequent to rejection or modification by the
19 commissioner.

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

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

24 (2) If the commissioner considers it to be in the best interests of the policyholders and
25 creditors of the health organization and of the public, take such actions as are necessary to cause
26 the health organization to be placed under regulatory control under article ten of this chapter. If
27 the commissioner takes such actions, the authorized control level event shall be considered
28 sufficient grounds for the commissioner to take action under article ten of this chapter, and the
29 commissioner has the rights, powers and duties with respect to the health organization as are set
30 forth in article ten of this chapter. If the commissioner takes actions under this subdivision
31 pursuant to an adjusted RBC report, the health organization is entitled to such protections as are
32 afforded to health organizations under article ten of this chapter pertaining to summary
33 proceedings.

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

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

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

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

7 (3) If, pursuant to section seven of this article, the health organization challenges an
8 adjusted RBC report that indicates the event in subdivision (1) of this subsection, notification by

9 the commissioner to the health organization that the commissioner has, after a hearing, rejected
10 the health organization's challenge.

11 (b) If it is a mandatory control level event, the commissioner shall take such actions as are
12 necessary to place the health organization under regulatory control under article ten of this
13 chapter. In that event, the mandatory control level event is sufficient grounds for the commissioner
14 to take action under article ten of this chapter, and the commissioner has the rights, powers and
15 duties with respect to the health organization as are set forth in article ten of this chapter. If the
16 commissioner takes actions pursuant to an adjusted RBC report, the health organization is
17 entitled to the protections of article ten of this chapter pertaining to summary proceedings.
18 Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety days
19 after the mandatory control level event if the commissioner finds there is a reasonable expectation
20 that the mandatory control level event may be eliminated within the ninety-day period.

§33-40A-7. Hearings.

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

8 The events include:

- 9 (a) Notification to a health organization by the commissioner of an adjusted RBC report;
- 10 (b) Notification to a health organization by the commissioner that:
 - 11 (1) The health organization's RBC plan or revised RBC plan is unsatisfactory; and
 - 12 (2) Notification constitutes a regulatory action level event with respect to the health
13 organization;

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

18 (d) Notification to a health organization by the commissioner of a corrective order with
19 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 required to be set forth in a publicly
2 available annual statement schedule) and RBC plans (including the results or report of any
3 examination or analysis of a health organization performed pursuant to this statute and any
4 corrective order issued by the commissioner pursuant to examination or analysis) with respect to
5 a domestic health organization or foreign health organization that are in the possession or control
6 of the commissioner are confidential by law and privileged, are not subject to the provisions of
7 chapter twenty-nine-b of this code, are not subject to subpoena, and are not subject to discovery
8 or admissible in evidence in any private civil action. However, the commissioner may use the
9 documents, materials or other information in the furtherance of any regulatory or legal action
10 brought as a part of the commissioner's official duties.

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

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

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

19 subsidiaries, and with state, federal and international law-enforcement authorities, provided that
20 the recipient agrees to maintain the confidentiality and privileged status of the document, material
21 or other information;

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

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

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

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

45 materially false statement with respect to the comparison regarding a health organization's total
46 adjusted capital to its RBC levels (or any of them) or an inappropriate comparison of any other
47 amount to the health organization's RBC levels is published in any written publication and the
48 health organization is able to demonstrate to the commissioner with substantial proof the falsity
49 of the statement, or the inappropriateness, as the case may be, then the health organization may
50 publish an announcement in a written publication if the sole purpose of the announcement is to
51 rebut the materially false statement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 (b) If there is a company action level event, regulatory action level event or authorized
11 control level event with respect to a foreign health organization as determined under the RBC
12 statute applicable in the state of domicile of the health organization (or, if no RBC statute is in
13 force in that state, under the provisions of this article), if the insurance commissioner of the state
14 of domicile of the foreign health organization fails to require the foreign health organization to file
15 an RBC plan in the manner specified under that state's RBC statute (or, if no RBC statute is in
16 force in that state, under section three of this article), the commissioner may require the foreign
17 health organization to file an RBC plan with the commissioner. The failure of the foreign health
18 organization to file an RBC plan with the commissioner is grounds to order the health organization
19 to cease and desist from writing new insurance business in this state.

20 (c) If there is a mandatory control level event with respect to a foreign health organization,
21 and no domiciliary receiver has been appointed with respect to the foreign health organization
22 under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign

23 health organization, the commissioner may make application to the circuit court of Kanawha
24 County permitted under section two, article ten of this chapter with respect to the liquidation of
25 property of foreign health organizations found in this state, and the occurrence of the mandatory
26 control level event shall be considered adequate grounds for the application.

§33-40A-11. Immunity.

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

§33-40A-12. Notices.

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

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

.....
Chairman, Senate Committee

.....
Chairman, House Committee

Originated in the Senate.

In effect 90 days from passage.

.....
Clerk of the Senate

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Clerk of the House of Delegates

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President of the Senate

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Speaker of the House of Delegates

The within this the.....
Day of, 2016.

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Governor