

WEST VIRGINIA LEGISLATURE

2021 REGULAR SESSION

Committee Substitute

for

House Bill 2876

BY DELEGATES WESTFALL AND SUMMERS

[Originating in the House Committee on Health and
Human Resources; Reported on March 26, 2021]

1 A BILL to amend and reenact §33-16-1a and §33-16-2 of the Code of West Virginia, 1931, as
2 amended; and to further amend said code by adding thereto a new section, designated
3 §33-16-2a, all relating to modify group accident and sickness insurance requirements.

Be it enacted by the Legislature of West Virginia:

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-1a. Definitions.

1 As used in this article:

2 ~~(a)~~ “Bona fide association” means an association ~~which has been actively in existence for~~
3 ~~at least five years; has been formed and maintained in good faith for purposes other than obtaining~~
4 ~~insurance~~ employers that are in the same trade, industry, line of business or profession: *Provided,*
5 That the association does not condition membership in the association on any health status-
6 related factor relating to an individual; makes accident and sickness insurance offered through
7 the association available to all members regardless of any health status-related factor relating to
8 members or individuals eligible for coverage through a member; does not make accident and
9 sickness insurance coverage offered through the association available other than in connection
10 with a member of the association; and meets any additional requirements as may be set forth in
11 this chapter or by rule.

12 ~~(b)~~ “Commissioner” means the commissioner of insurance.

13 ~~(c)~~ “Creditable coverage” means, with respect to an individual, coverage of the individual
14 after June 30, 1996, under any of the following, other than coverage consisting solely of excepted
15 benefits:

16 (1) A group health plan;

17 (2) A health benefit plan;

18 (3) Medicare Part A or Part B, 42 U. S. C. §1395 *et seq.*; Medicaid, 42 U. S. C. §1396a *et*
19 *seq.* (other than coverage consisting solely of benefits under Section 1928 of the Social Security

20 Act); Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), 10 U. S. C.,
21 Chapter 55; and a medical care program of the Indian Health Service or of a tribal organization;

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

26 ~~(d)~~ "Dependent" means an eligible employee's spouse or any unmarried child or stepchild
27 under the age of 25 if that child or stepchild meets the definition of a "qualifying child" or a
28 "qualifying relative" in section 152 of the Internal Revenue Code.

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

31 ~~(f)~~ "Excepted benefits" means:

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

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

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

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

45 “Excess insurance” or “stop-loss insurance” means an insurance policy purchased by a
46 multiple employer welfare arrangement under which it receives reimbursement for benefits it pays
47 in excess of a preset deductible or limit.

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

51 “Group self-insurance program” means a program by which benefits are provided to
52 members, employees of members, or the dependents of such members or employees, other than
53 through sickness and accident insurance purchased from an insurance company licensed to do
54 business in this state or health care services purchased from a hospital, medical or health service
55 corporation or health maintenance organization authorized to do business in this state.

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

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

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

69 (k) “Medical care” means amounts paid for, or paid for insurance covering, the diagnosis,
70 cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting

71 any structure or function of the body, including amounts paid for transportation primarily for and
72 essential to such care.

73 ~~(j)~~ “Mental health benefits” means benefits with respect to mental health services, as
74 defined under the terms of a group health plan or a health benefit plan offered in connection with
75 the group health plan.

76 “Multiple employer welfare arrangement” means an employee welfare benefit plan, trust,
77 or any other arrangement, whether such plan, trust, or arrangement is subject to the “Employee
78 Retirement Income Security Act of 1974,” as amended, that is established or maintained for the
79 purpose of offering or providing, through group insurance or group self-insurance programs,
80 medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident,
81 disability, or death, to the employees, and their dependents, of two or more employers, or to two
82 or more self-employed individuals and their dependents.

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

86 “Self-employed individual with no employees” means an individual that:

87 (1) Has an ownership right in a “trade or business,” regardless of whether the “trade or
88 business” is incorporated or unincorporated;

89 (2) Earns wages or self-employment income from the “trade or business”; and

90 (3) Works at least 20 hours a week (or 80 hours per month) providing personal services
91 to the “trade or business” or earns income from the “trade or business” that at least equals the
92 self-employed individual’s cost of any health coverage in which the individual enrolls. For purpose
93 of this article, a self-employed individual with no employees shall be considered an employer and
94 an employee.

§33-16-2. Eligible groups.

1 Any insurer licensed to transact accident and sickness insurance in this state may issue
2 group accident and sickness policies coming within any of the following classifications:

3 (1) A policy issued to an employer, who shall be considered the policyholder, insuring at
4 least two employees of the employer, for the benefit of persons other than the employer, and
5 conforming to the following requirements:

6 (A) If the premium is paid by the employer the group shall comprise all employees or all
7 of any class or classes thereof determined by conditions pertaining to the employment; or

8 (B) If the premium is paid by the employer and the employees jointly, or by the employees,
9 there shall be no employee participation requirement. The term "employee" as used herein is
10 considered to include the officers, managers and employees of the employer, the partners, if the
11 employer is a partnership, the officers, managers and employees of subsidiary or affiliated
12 corporations of a corporate employer, and the individual proprietors, partners and employees of
13 individuals and firms, the business of which is controlled by the insured employer through stock
14 ownership, contract or otherwise. The term "employer" as used herein may include any municipal
15 or governmental corporation, unit, agency or department and the proper officers of any
16 unincorporated municipality or department, as well as private individuals, partnerships and
17 corporations.

18 (2) A policy issued to an association or to a trust or to the trustees of a fund established,
19 created or maintained for the benefit of members of one or more associations. The association or
20 associations shall have at the issuance of the policy a minimum of ~~one hundred~~ fifty persons and
21 have been organized and maintained in good faith for purposes other than that of obtaining
22 insurance; shall have been in active existence for at least one year; and shall have a Constitution
23 and bylaws that provide that: The association or associations hold regular meetings not less than
24 annually to further the purposes of the members; except for credit unions, the association or
25 associations collect dues or solicit contributions from members; and the members have voting

26 privileges and representation on the governing board and committees. The policy is subject to the
27 following requirements:

28 (A) The policy may insure members of the association or associations, employees thereof
29 or employees of members or one or more of the preceding or all of any class or classes for the
30 benefit of persons other than the employee's employer.

31 (B) The premium for the policy shall be paid from:

32 (i) Funds contributed by the association or associations;

33 (ii) Funds contributed by covered employer members;

34 (iii) Funds contributed by both covered employer members and the association or
35 associations;

36 (iv) Funds contributed by the covered persons; or

37 (v) Funds contributed by both the covered persons and the association, associations or
38 employer members.

39 (C) Except as provided in paragraph (D) of this subdivision, a policy on which no part of
40 the premium is to be derived from funds contributed by the covered persons specifically for their
41 insurance must insure all eligible persons, except those who reject coverage in writing.

42 (D) An insurer may exclude or limit the coverage on any person as to whom evidence of
43 individual insurability is not satisfactory to the insurer.

44 (E) A small employer, as defined in §33-16D-2(r) of this code, insured under an eligible
45 group policy provided in this subdivision shall also be subject to the marketing and rate practices
46 provisions in §33-16D-1 *et seq.* of this code.

47 (3) A policy issued to a bona fide association.

48 (4) A policy issued to a college, school or other institution of learning or to the head or
49 principal thereof, insuring at least ten students, or students and employees, of the institution;

50 (5) A policy issued to or in the name of any volunteer fire department, insuring all of the
51 members of the department or all of any class or classes thereof against any one or more of the

52 hazards to which they are exposed by reason of the membership but in each case not less than
53 10 members;

54 (6) A policy issued to any person or organization to which a policy of group life insurance
55 may be issued or delivered in this state, to insure any class or classes of individuals that could be
56 insured under the group life policy; and

57 (7) A policy issued to cover any other substantially similar group which in the discretion of
58 the commissioner may be subject to the issuance of a group accident and sickness policy or
59 contract.

§33-16-2a. Self-insured multiple employer welfare arrangements.

1 Effective July, 2022 to the extent allowed by federal law and in good standing, a bona fide
2 association shall be allowed to sponsor and operate a self-insured multiple employer welfare
3 arrangement in this state, if it meets the following requirements:

4 (1) No bona fide association shall be permitted to sponsor a group self-insurance program
5 or self-insured multiple employer welfare arrangement unless it has been issued a certificate of
6 authority by the commissioner.

7 (2) When applying for a certificate of authority to sponsor a proposed group self-insurance
8 program or self-insured multiple employer welfare arrangement, the bona fide association shall
9 file with the commissioner a nonrefundable filing fee of one thousand dollars and an application
10 setting forth all of the following:

11 (A) The name of each arrangement;

12 (B) The address of each arrangement's principal place of business;

13 (C) The name and address of a resident of this state designated and appointed as the
14 registered agent of each proposed arrangement for service of process in this state. The person
15 so designated and appointed shall be an officer of the arrangement.

16 (D) The names and addresses of the officers, directors, and trustees of each proposed
17 arrangement and a statement of whether any of such officers, directors, and trustees have been
18 convicted of any felony or misdemeanor within ten years prior to the date of the application;

19 (E) The powers of the officers, directors, and trustees;

20 (F) The term of office of each officer, director, and trustee;

21 (G) A brief outline of the method by which the administrative obligations of each
22 arrangement will be met;

23 (H) A business plan describing the arrangement's anticipated method of operations for
24 two years from its commencement of activities.

25 (I) A copy of the articles and bylaws of each arrangement;

26 (J) A copy of the agreement;

27 (K) The name and address of all third-party administrators;

28 (L) A copy of each agreement between each arrangement and all third-party
29 administrators;

30 (M) A statement certified by an independent certified public accountant regarding the
31 financial condition of each arrangement listing, on a form as may be prescribed by the
32 commissioner, all of its assets and liabilities for the last month ending forty-five days prior to the
33 application date;

34 (N) A copy of each contract, certificate, endorsement, and application form each proposed
35 arrangement intends to issue or use;

36 (O) The names of any co-sponsors, promoters, trustees, or other facilitators involved with
37 the establishment of each arrangement;

38 (P) Other information, documents, or statements as the commissioner requires.

39 (3) The arrangement shall at all times be in compliance with federal law and regulation,
40 including but not limited to the Employee Retirement Income Security act of 1974, as amended,
41 and the regulations thereunder;

42 (4) The arrangement's governing documents shall require the arrangement to be operated
43 in accordance with sound actuarial principles and the arrangement shall be operated in
44 accordance with those principles;

45 (5) The arrangement shall be subject to §33-11-1 et seq. of this code, and shall not;

46 (A) Refuse, without just cause, to pay proper claims arising under coverage provided by
47 the arrangement;

48 (B) Enroll a member into the group self-insurance program or self-insured multiple
49 employer welfare arrangement until the arrangement has provided to the member written
50 notification stating that the member may be required to make additional payments in the event
51 the program has insufficient funds to cover its liabilities. The arrangement shall maintain a copy
52 of the notification in its program files to evidence compliance with this requirement; or

53 (C) Allow an officer, director, trustee, third-party administrator, member of any board or
54 committee, or employee the arrangement who is charged with the duty of investing or handling
55 the arrangement's assets to deposit or invest the assets except in the name of the arrangement,
56 borrow the assets of the arrangement, have a pecuniary interest in any loan, pledge of deposit,
57 security, investment, sale, purchase, exchange, reinsurance, or other similar transaction or
58 property of the arrangement, take or receive for personal use any fee, brokerage, commission,
59 gift, or other consideration for, or use any fee, brokerage, commission, gift, or other consideration
60 for, or on account of any transaction made by or on behalf of the arrangement, or guarantee any
61 financial obligation of any of its officers, directors, trustees, board or committee members, or third-
62 party administrators: *Provided*, That this does not prohibit a trustee, officer, director, member of
63 a board or committee, or employee from being covered by the arrangement as a member or an
64 employee of a member.

65 (6) The commissioner may examine, as often as necessary, the affairs of the arrangement
66 and its members as permitted by §33-2-9 of this code. The arrangement may be required to pay

67 the commissioner for the expenses incurred by the agency in making an examination authorized
68 under this section.

69 (7) The commissioner may determine the financial capacity of the arrangement operating
70 a group self-insurance program or self-insured multiple welfare arrangement to pay employee
71 welfare benefit obligations promptly and to otherwise meet its obligations. In doing so, the
72 commissioner may take into consideration all of the following:

73 (A) Maintenance of minimum reserves that are necessary in the exercise of sound and
74 prudent actuarial judgment either/and that are certified by a member of the American academy of
75 actuaries as having been computed in accordance with accepted loss reserving standards and
76 as being fairly stated in accordance with sound loss reserving principles, or determined to be
77 sufficient through such other documentation acceptable to the commissioner;

78 (B) The existence and face value of contracts or policies of excess insurance;

79 (C) Any other measure of financial capacity as the commissioner considers appropriate.

80 (8) Each arrangement shall, no later than the thirty-first day of March, make and file with
81 the commissioner an annual report of its affairs and operations during the last preceding calendar
82 year. The report shall be made pursuant to forms prescribed or designated by the commissioner.
83 The commissioner may determine accounting practices and methods for purposes of preparing
84 financial statements and other financial information. A bona fide association that fails to file an
85 annual report is subject to suspension or revocation of its certificate of authority.

86 (9) Each arrangement shall file with the commissioner its excess loss funding program.
87 A bona fide association sponsoring a group self-insurance program or self-insured multiple
88 employer welfare arrangement shall purchase individual stop-loss insurance from insurers
89 authorized to transact business in this state with a deductible retention of no more than five per
90 cent of the arrangement's annual aggregate premium up to one million dollars and no more than
91 two and one-half per cent of the arrangement's annual aggregate premium above that amount.
92 The arrangement also shall purchase, as a condition to the issuance and maintenance of a

93 certificate of authority, aggregate stop-loss insurance from insurers authorized to transact
94 business in this state with a deductible retention of no more than one hundred twenty-five per
95 cent of its projected claims for the succeeding fiscal year. The commissioner shall be notified of
96 the cancellation of the policy for any reason, including the failure to pay any applicable premium,
97 within 15 days thereof.

98 (10) Each arrangement shall maintain a minimum surplus as established by rule of the
99 commissioner for the protection of the members and their employees. The assets of a group self-
100 insurance program or self-insured multiple employer welfare arrangement shall be invested only
101 in securities or other investments permitted by the laws of this state for the investment of assets
102 of domestic insurance companies other than life.

103 (11) Each arrangement shall contract only with a third-party administrator that has and
104 maintains a fidelity bond as required by the "Employee Retirement Income Security Act of 1974,"
105 as amended, and has and maintains errors and omissions coverage or other appropriate liability
106 insurance in an amount set forth in rules promulgated by the commissioner. The certificate of the
107 insurer or other appropriate evidence of such coverage or insurance shall be filed with the
108 commissioner.

109 (12) The Insurance Commissioner may propose rules for legislative approval in
110 accordance with §29A-3-1 et seq. of this code regulating group self-insurance programs or self-
111 insured multiple employer welfare arrangements in a manner consistent with this section. Rules
112 adopted pursuant to this section may set forth an application process, minimum financial solvency
113 including capital and surplus requirements, prohibited acts, annual filing requirements, financial
114 capacity requirements, penalties or fines, including, without limitation, monetary fines, suspension
115 of licensure, and revocation of licensure for violations of this section and the rules adopted
116 pursuant to this section.

NOTE: The purpose of this bill is to modify the five-year waiting period and 100-person minimum for an association health plan, and to allow new flexibility granted under federal rules.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.