WEST VIRGINIA LEGISLATURE 2023 REGULAR SESSION

Committee Substitute

for

Senate Bill 480

By Senators Oliverio, Azinger, Barrett, and Queen
[Originating in the Committee on Banking and
Insurance; reported on February 21, 2023]

A BILL to amend and reenact §33-16-1a and §33-16-2 of the Code of West Virginia, 1931, as amended; and to amend said code by adding thereto a new section, designated §33-16-2a, all relating to modifying group accident and sickness insurance requirements and permitting self-insured multiple employer welfare arrangements; modifying and creating definitions; reducing requirements for bona fide associations; authorizing bona fide associations in good standing to sponsor and operate self-insured multiple employer welfare arrangements if certain requirements are met; setting forth requirements for self-insured multiple employer welfare arrangements; authorizing Insurance Commissioner to issue certificates of authority; imposing a non-refundable filing fee; requiring annual reporting by the arrangements; requiring rulemaking by Insurance Commissioner; and authorizing rulemaking on penalties, fines, and suspension and revocation of certificates of authority for violations of requirements for multiple employer welfare arrangements.

Be it enacted by the Legislature of West Virginia:

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-1a. Definitions.

As used in this article:

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

12 (b) "Commissioner" means the	commissioner of insurance
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- (c) "Creditable coverage" means, with respect to an individual, coverage of the individual after June 30, 1996, under any of the following, other than coverage consisting solely of excepted benefits:
 - (1) A group health plan;
- (2) A health benefit plan;
- (3) Medicare Part A or Part B, 42 U. S. C. § 1395 *et seq.*; Medicaid, 42 U. S. C. § 1396a *et seq.* (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act); Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), 10 U. S. C., Chapter 55; and a medical care program of the Indian Health Service or of a tribal organization;
- (4) A health benefits risk pool sponsored by any state of the United States or by the District of Columbia; a health plan offered under 5 U. S. C., Chapter 89; a public health plan as defined in regulations promulgated by the federal secretary of health and human services; or a health benefit plan as defined in the Peace Corps Act, 22 U. S. C. §2504(e).
- (d) "Dependent" means an eligible employee's spouse or any unmarried child or stepchild under the age of 25 if that child or stepchild meets the definition of a "qualifying child" or a "qualifying relative" in section 152 of the Internal Revenue Code 26.
- (e) "Eligible employee" means an employee, including an individual who either works or resides in this state, who meets all requirements for enrollment in a health benefit plan.
 - (f) "Excepted benefits" means:
- (1) Any policy of liability insurance or contract supplemental thereto; coverage only for accident or disability income insurance or any combination thereof; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; workers' compensation insurance; or other similar insurance under which benefits for medical care are secondary or incidental to other insurance benefits; or

- (2) If offered separately, a policy providing benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, dental or vision benefits or other similar, limited benefits; or
- (3) If offered as independent, noncoordinated benefits under separate policies or certificates, specified disease or illness coverage, hospital indemnity or other fixed indemnity insurance, or coverage, such as Medicare supplement insurance, supplemental to a group health plan; or
 - (4) A policy of accident and sickness insurance covering a period of less than one year.
- (g) "Excess insurance" or "stop-loss insurance" means an insurance policy purchased by a multiple employer welfare arrangement under which it receives reimbursement for benefits it pays in excess of a preset deductible or limit.
- (g) (h) "Group health plan" means an employee welfare benefit plan, including a church plan or a governmental plan, all as defined in section three of the Employee Retirement Income Security Act of 1974, 29 U. S. C. § 1003, to the extent that the plan provides medical care.
- (i) "Group self-insurance program" means a program by which benefits are provided to members, employees of members, or the dependents of such members or employees other than through sickness and accident insurance purchased from an insurance company licensed to do business in this state, health care services purchased from a hospital, medical, or health service corporation, or health maintenance organization authorized to do business in this state.
- (h) (j) "Health benefit plan" means benefits consisting of medical care provided directly, through insurance or reimbursement, or indirectly, including items and services paid for as medical care, under any hospital or medical expense incurred policy or certificate; hospital, medical or health service corporation contract; health maintenance organization contract; or plan provided by a multiple employer trust or a multiple employer welfare arrangement. "Health benefit plan" does not include excepted benefits.

- (i) (k) "Health insurer" means an entity licensed by the commissioner to transact accident and sickness in this state and subject to this chapter. "Health insurer" does not include a group health plan.
- (j) (l) "Health status-related factor" means an individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) or disability.
- (k) (m) "Medical care" means amounts paid for, or paid for insurance covering, the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, including amounts paid for transportation primarily for and essential to such care.
- (I) (n) "Mental health benefits" means benefits with respect to mental health services, as defined under the terms of a group health plan or a health benefit plan offered in connection with the group health plan.
- (o) "Multiple employer welfare arrangement" means an employee welfare benefit plan, trust, or any other arrangement, subject to the Employee Retirement Income Security Act of 1974, as amended, that is established or maintained for the purpose of offering or providing, through group insurance or group self-insurance programs, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, or death, to employees of two or more employers (including one or more self-employed individuals) and their dependents. As it relates to multiple employer welfare arrangements, the term "self-employed individuals" includes any working owners and persons to the extent they are allowed under federal law to be a part of a bona fide association.
- (m) (p) "Network plan" means a health benefit plan under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the health insurer.

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

§33-16-2. Eligible groups.

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

- (1) A policy issued to an employer, who shall be considered the policyholder, insuring at least two employees of the employer, for the benefit of persons other than the employer, and conforming to the following requirements:
- (A) If the premium is paid by the employer the group shall comprise all employees or all of any class or classes thereof determined by conditions pertaining to the employment; or
- (B) If the premium is paid by the employer and the employees jointly, or by the employees, there shall be no employee participation requirement. The term "employee" as used herein is considered to include the officers, managers and employees of the employer, the partners, if the employer is a partnership, the officers, managers, and employees of subsidiary or affiliated corporations of a corporate employer, and the individual proprietors, partners and employees of individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract or otherwise. The term "employer" as used herein may include any municipal or governmental corporation, unit, agency or department and the proper officers of any unincorporated municipality or department, as well as private individuals, partnerships, and corporations.
- (2) A policy issued to an association or to a trust or to the trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the issuance of the policy a minimum of one hundred 50 persons and have been organized and maintained in good faith for purposes other than that of obtaining

insurance; shall have been in active existence for at least one year; and shall have a Constitution and bylaws that provide that: The association or associations hold regular meetings not less than annually to further the purposes of the members; except for credit unions, the association or associations collect dues or solicit contributions from members; and the members have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

- (A) The policy may insure members of the association or associations, employees thereof or employees of members or one or more of the preceding or all of any class or classes for the benefit of persons other than the employee's employer.
 - (B) The premium for the policy shall be paid from:
 - (i) Funds contributed by the association or associations;
 - (ii) Funds contributed by covered employer members;
- (iii) Funds contributed by both covered employer members and the association or associations;
 - (iv) Funds contributed by the covered persons; or
- (v) Funds contributed by both the covered persons and the association, associations, or employer members.
- (C) Except as provided in paragraph (D) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject coverage in writing.
- (D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.
- (E) A small employer, as defined in §33-16D-2(r) of this code, insured under an eligible group policy provided in this subdivision shall also be subject to the marketing and rate practices provisions in §33-16D-1 *et seq.* of this code.
 - (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 10 students, or students and employees, of the institution;

- (5) A policy issued to or in the name of any volunteer fire department, insuring all of the members of the department or all of any class or classes thereof against any one or more of the hazards to which they are exposed by reason of the membership but in each case not less than 10 members;
- (6) A policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state, to insure any class or classes of individuals that could be insured under the group life policy; and
- (7) A policy issued to cover any other substantially similar group which in the discretion of the commissioner may be subject to the issuance of a group accident and sickness policy or contract.

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

- (a) Effective July 1, 2024, to the extent allowed by federal law, a bona fide association in good standing is authorized to sponsor and operate a self-insured multiple employer welfare arrangement in this state: *Provided*, That the following requirements are met:
- (1) The association has been issued a certificate of authority by the commissioner to sponsor and operate a self-insured multiple employer welfare arrangement. When applying for a certificate of authority to sponsor a self-insured multiple employer welfare arrangement, the bona fide association shall submit to the commissioner a nonrefundable filing fee of \$1,000 and an application setting forth all of the following:
 - (A) The name of the arrangement;
 - (B) The address of the arrangement's principal place of business;
- (C) The name and address of a resident of this state designated and appointed as the registered agent of the proposed arrangement for service of process in this state. The person so designated and appointed shall be an officer of the arrangement;

14	(D) The names and addresses of the officers, directors, and trustees of the proposed
15	arrangement and a statement of whether any of such officers, directors, and trustees have been
16	convicted of any felony or misdemeanor within 10 years prior to the date of the application;
17	(E) The powers of the officers, directors, and trustees;
18	(F) The term of office of each officer, director, and trustee;
19	(G) An outline of the method by which the administrative obligations of the arrangement
20	will be met;
21	(H) A business plan describing the arrangement's anticipated method of operations;
22	(I) A copy of the articles and bylaws of the arrangement;
23	(J) A copy of the agreement;
24	(K) The name and address of all third-party administrators;
25	(L) A copy of the agreement between the arrangement and all third-party administrators;
26	(M) A statement certified by an independent certified public accountant, which includes an
27	actuarial certification, regarding the financial condition of the arrangement and listing, on a form
28	as may be prescribed by the commissioner, all of its assets and liabilities for the last month ending
29	45 days prior to the application date:
30	(N) A copy of each contract, certificate, endorsement, and application form the proposed
31	arrangement intends to issue or use;
32	(O) The names of any co-sponsors, promoters, trustees, or other facilitators involved with
33	the establishment of the arrangement; and
34	(P) Additional information, documents, or statements that the commissioner may require;
35	(2) The arrangement shall at all times be in compliance with applicable federal laws and
36	regulations, including, but not limited to, the Employee Retirement Income Security Act of 1974,
37	as amended, and the regulations thereunder;

38	(3) The arrangement's governing documents shall require the arrangement to be operated
39	in accordance with sound actuarial principles, and the arrangement shall be operated in
40	accordance with those principles;
11	(4) The arrangement shall be subject to §33-11-1 et seq. of this code and shall not;
12	(A) Refuse to pay proper claims arising under coverage provided by the arrangement
13	without just cause;
14	(B) Enroll a member into the self-insured multiple employer welfare arrangement until the
1 5	arrangement has provided to the member written notification stating that the member may be
1 6	required to make additional payments in the event the arrangement has insufficient funds to cover
17	its liabilities. The arrangement shall maintain a copy of the notification in its files to evidence
18	compliance with this requirement; or
19	(C) Allow an officer, director, trustee, third-party administrator, member of any board or
50	committee, or employee of the arrangement who is charged with the duty of investing or handling
51	the arrangement's assets to deposit or invest the assets except in the name of the arrangement.
52	borrow the assets of the arrangement, have a pecuniary interest in any loan, pledge of deposit
53	security, investment, sale, purchase, exchange, reinsurance, or other similar transaction or
54	property of the arrangement, take or receive for personal use any fee, brokerage, commission,
55	gift, or other consideration for, or use any fee, brokerage, commission, gift, or other consideration
56	for, or on account of any transaction made by or on behalf of the arrangement, or guarantee any
57	financial obligation of any of its officers, directors, trustees, board or committee members, or third-
58	party administrators: Provided, That this paragraph does not prohibit a trustee, officer, director,
59	member of a board or committee, or employee from being covered by the arrangement as a
60	member or an employee of a member;
31	(5) The commissioner may examine, as often as reasonably required, the affairs of the
62	arrangement and its members as permitted by §33-2-9 of this code. The cost of any such

examination shall be the responsibility of the arrangement;

(6) The commissioner may examine and determine the financial soundness of the bona
fide association operating a self-insured multiple welfare arrangement to ensure the association's
ability to pay employee welfare benefit obligations promptly and to otherwise meet its obligations.
In doing so, the commissioner may take into consideration all of the following:

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

- (B) The existence and face value of contracts or policies of excess insurance; and
- (C) Any other measure of financial capacity the commissioner deems appropriate;
- (7) Each arrangement shall annually, no later than the 31st day of March, make and file with the commissioner an annual report of its affairs and operations during the last preceding calendar year. The report shall be made pursuant to forms prescribed or designated by the commissioner. The commissioner may determine accounting practices and methods for purposes of preparing financial statements and other financial information. A bona fide association that fails to file an annual report is subject to suspension or revocation of its certificate of authority;
- (8) Each arrangement shall file with the commissioner its excess loss funding program. A bona fide association sponsoring a self-insured multiple employer welfare arrangement shall purchase individual stop-loss insurance from insurers authorized to transact business in this state with a deductible retention of no more than five percent of the arrangement's annual aggregate premium up to \$1 million and no more than two and one-half percent of the arrangement's annual aggregate premium above that amount. The arrangement also shall purchase, as a condition to the issuance and maintenance of a certificate of authority, aggregate stop-loss insurance from insurers authorized to transact business in this state with a deductible retention of no more than 125 percent of its projected claims for the succeeding fiscal year: *Provided*, That the arrangement

shall notify the commissioner immediately of the cancellation of the insurance for any reason, including the failure to pay any applicable premium, no later than 15 days thereof;

- (9) Each arrangement shall maintain a minimum surplus as established by rule of the commissioner for the protection of its members and their employees. The assets of the arrangement shall be invested only in securities or other investments permitted by the laws of this state for the investment of assets of domestic insurance companies other than life; and
- (10) Each arrangement shall contract only with a third-party administrator that has and maintains a fidelity bond as required by the Employee Retirement Income Security Act of 1974, as amended, and that has and maintains errors and omissions insurance coverage or other appropriate liability insurance in an amount set forth by rule of the commissioner in. The certificate of the insurer or other appropriate evidence of such coverage or insurance shall be filed with the commissioner.
- (b) The Insurance Commissioner shall propose rules for legislative approval in accordance with the provisions of §29A-3-1 *et seq.* of this code regulating self-insured multiple employer welfare arrangements, including group self-insurance programs, in a manner consistent with this section. The rules may include, but are not limited to, the application process, minimum financial solvency and capital and surplus requirements, prohibited acts, participation limitations, annual filing requirements, financial capacity requirements, and penalties and reasonable fines, and suspension and revocation of a certificate of authority, for violations of this section or the rules adopted pursuant to this section.