

WEST VIRGINIA INFORMATIONAL LETTER

NO. 77

APRIL, 1991

TO: All Insurance Companies Licensed To Do Business In The State of West Virginia, Insurance Trade Associations, Insurance Media Publications and All Other Interested Persons

The purpose of this Informational Letter is to briefly summarize significant insurance legislation enacted during the 1991 regular session of the West Virginia Legislature. This letter is not to be construed as inclusive of all legislation which may effect the insurance industry or insurance consumers, but rather, is intended to highlight the more important bills.

Persons seeking a copy of particular legislation should contact the West Virginia Legislature, Senate Clerks Office 304/357-7800 or House Clerks Office 304/340-3200, Main Unit, State Capitol, Charleston, West Virginia 25305.

SUMMARY OF 1991 LEGISLATION

Senate Bill 143 -- Life and Accident and Sickness Applications and Policies

This bill establishes certain requirements for applications and policies of life and accident and sickness insurance.

Applications must include: (1) signatures of both the agent and the proposed insured; (2) completion by a licensed and appointed agent in the presence of the insured; (3) if application is made upon a spouse by another spouse, the signatures of the spouse procuring the insurance and the agent; and (4) the signatures of the person procuring insurance and the agent when application is made by any person having insurable interest in the life of a minor or any person upon whom a minor is dependent for support and maintenance. Certain applications, including those for mass-marketed products and retirement plans for employees of the governing boards of higher education institutions, are exempted from these provisions.

Any amendments to the application, after it is originally signed by the proposed insured, must be disclosed to the insured in writing requiring his or her signature to verify these changes.

Regarding life and accident and sickness policies, proof of delivery to insureds is mandated. If a policy is hand delivered to the insured a delivery receipt must be signed and dated by the insured and returned to the company for filing. If delivery is by mail, it must be either by certified mail or the company prepares a certificate of mailing.

On the first page of all such policies, a notice must be prominently printed that the insured has the right to return the policy within ten (10) days of receipt and have the premiums refunded.

This legislation became **effective March 9, 1991.**

**Senate Bill 535 -- Guaranteed Loss Ratios for
Individual Accident and Sickness Policies;
Basic Health Plan; and Marketing and Rate Practices
for Small Employer Group Accident and Sickness
Policies**

The first aspect of this bill directs the Commissioner to establish a guaranteed loss ratio which may be used by any company offering individual accident and sickness policies. Calculations for the loss ratio will be made by the Commissioner and each individual insurer and will be based upon various sources, including the N.A.I.C. guidelines. Any guaranteed loss ratio less than fifty-five percent (55%) is prohibited. The guaranteed loss ratio will be based upon experience periods during which the insurer earns one million dollars (\$1,000,000) in premiums in West Virginia. If the annual earned premium volume in West Virginia is less than one million dollars (\$1,000,000), then the loss ratio will be based on other actuarially sound methods as deemed appropriate by the Commissioner. If an insurers application for guaranteed loss ratio is approved, then the company is exempt from prior agency approval for rate increases.

The guaranteed loss ratio results will be independently audited at the insurers expense with each audit to be finalized in the second quarter of the year following the end of the experience period; the audit results are to be reported to this Commission no later than June 30 following the end of the experience period.

The insurer must also guarantee that if the actual loss ratio during an experience period is less than the anticipated loss ratio for that period, then its West Virginia policyholders will receive a proportional refund based upon premium earned.

The Commissioner may reject any loss ratio guarantee within sixty (60) days from date of filing with this office for any of the six reasons defined in this bill. If it is found upon review and investigation that a previously approved loss ratio guarantee is no longer complying with the statutory provisions, the Commissioner may reject or cancel said loss ratio guarantee. In either situation the insurer has the right to challenge the decision by due process of administrative hearing.

Senate Bill 535 (continued)

The second and third portions of this bill mandate the creation of a basic health policy for individual as well as group accident and sickness coverage, respectively. Within six (6) months of the effective date of this bill, the Commissioner is to finalize the structures of these policies. Such policies are exempt from all statutorily mandated benefits except those established by the Commissioner. Offers of any additional benefits are permissible for the appropriate additional premiums. These policies may include deductibles, co-payments and maximum benefits. Premiums paid for these policies are exempt from premium taxes.

Regarding the basic group accident and sickness health policy, all communication used in marketing this product must have prior approval by this Agency. Those employers, eligible for this policy, constitute a corporation, partnership or proprietorship which has done business in this State for at least one (1) year. These employers may subscribe any employee who works on an average of at least twenty (20) hours per week to this policy.

The fourth portion of this bill establishes standards for marketing and rate practices of any health benefit plan which provides coverage to two (2) or more employees of small employers in West Virginia. Any person, firm, corporation, partnership or association engaged in this State for at least one (1) year and employs no more than forty-nine (49) or at least two (2) employees constitutes a small employer. Multiple Employer Trusts and Multiple Employer Welfare Arrangements which offer these benefit plans to small employers fall under this bill's jurisdiction.

Discriminatory practices in marketing these health benefit plans are prohibited. If an insurer is found to be conducting such practices, a fine of not more than ten thousand dollars (\$10,000) shall be imposed. Upon a second violation the Commissioner has the authority to revoke the insurer's license to transact insurance.

This bill creates rather specific measures with which insurers must comply to obtain premium rate increases for small employers' group policies. The rate increases charged to a small employer for a new rating period may not exceed the arithmetic sum of the following: a) the percentage charge measured from the first day of the new rating period; b) the percentage of rate increases attributable to claim experience, including trends, which cannot exceed fifteen percent (15%) and can be prorated; and c) the percentage rate increase attributed to case characteristic. To be eligible for a rate increase after July 1, 1991, an insurer must have a minimum anticipated loss ratio of sixty-five percent (65%). Prior to any increase, the Commissioner must conduct a public hearing.

Senate Bill 535 – (continued)

All insurers shall be prohibited from distinguishing more than four (4) classes of business within their small group insurance coverage after June 30, 1993.

Health benefit plans shall be renewable to all employees at the option of the small employers. However, five specific incidences are noted when insurers may refuse renewals.

The insurer must make disclosures of rating practices and renewability provisions in marketing materials provided to the small employer. Such disclosures must include: a) a description of the small employers class of business; b) the extent to which premium rates are established or adjusted; c) provisions of the insurer's right to change premium rates; d) provisions relating to coverage renewability and e) an explanation, if applicable, that the employer is purchasing a minimum benefits plan.

Restrictions on the use of pre-existing conditions in these health plans are stipulated. Pre-existing conditions shall not exclude coverage for a period beyond twelve (12) months following an individual's effective date of coverage. For those individuals who have been covered under a previous comparable plan, this twelve month pre-existing condition clause applies if the previous coverage was continuous to a date of not more than thirty (30) days prior to the effective date of the new coverage.

All requirements of the marketing and rate practices for small employer accident and sickness policies may be suspended if the Commissioner finds that: a) the financial condition of the insurer warrants such action, or b) the efficiency and fairness of the market place for small employer health insurance would be enhanced.

Applicability of this section includes service corporations, health care corporations and health maintenance organizations.

This legislation becomes **effective July 1, 1991.**

Senate Bill 616 -- Liability Coverage Extended to Loan Vehicles

Every policy of personal automobile liability insurance shall extend its coverage to insured individuals when operating a motor vehicle loaned to them by a person or company engaged in the business of selling, repairing or servicing while the insureds vehicle is out of use because of breakdown, repair or service. The extension of property damage coverage shall include coverage for damage to or loss of the vehicle due to negligence of the insured.

This legislation becomes **effective June 5, 1991.**

**Senate Bill 631 -- No Exclusion of Coverage Allowed
For Insureds Children in Individual
and Group Accident and Sickness Policies**

This bill directs that any insurer who writes individual or group accident and sickness policies must provide coverage for the child or children of the insured without regard to the following facts: 1) the insured may not have legal custody of the child or children; 2) the child or children may not reside in the insureds home and 3) the amount of child support paid by the insured.

This legislation becomes **effective June 6, 1991.**

Senate Bill 637 -- Authorization of Administrative Regulations

This bill authorizes the promulgation of the following administrative regulations: Excess Line Brokers; Examiners Compensation, Qualification and Classification; West Virginia Essential Property Insurance Association; Medical Malpractice Annual Reporting Requirements; Medical Malpractice Loss Experience and Loss Expense Reporting Requirements; Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions; Insurance Adjusters; Accident and Sickness Rate Filing; Group Coordination of Benefits; AIDS Regulations and Health Insurance Benefits for Temporomandibular and Craniomandibular Disorders.

This legislation became **effective March 9, 1991.**

House Bill 2462 -- Insurance Insolvency Prevention

This bill is quite comprehensive in scope and enacts measures on various subjects. Those measures so implemented are:

Examination of insurers: On or before the first day of July 1991 and every first day of July thereafter, each licensed company shall pay an examination assessment fee of eight hundred dollars (\$800). Four hundred and fifty dollars (\$450) will be placed in a special revolving fund known as "Commissioners Examination Revolving Fund" and three hundred and fifty dollars (\$350) will be paid to the State Treasurer.

The Commissioner may, at his discretion, increase this examination assessment fee by two hundred and fifty dollars (\$250), after proper notice to all involved insurers. This additional levy will be credited to the "Commissioners Examination Revolving Fund."

Those monies in the "Commissioners Examination Revolving Fund" are for costs expended in the examinations of companies or for the purchase of equipment, supplies, travel, education and training for his deputies, examiners and other employees necessary to fulfill statutory obligations in this section of the West Virginia Code.

This statute applies to the following insurance entities: domestic or foreign stock companies, mutual companies, farmers mutual companies, fraternal benefit societies, reciprocals, nonprofit service corporations, health care corporations, health maintenance organizations, captive insurance companies and risk retention groups.

Minimum Capital and Surplus Requirements: The one million dollars (\$1,000,000) capital and one million dollars (\$1,000,000) surplus required of all licensed insurers must be unencumbered.

Annual Financial Statements: All financial statements are to be filed on the N.A.I.C. (National Association of Insurance Commissioners) form and prepared in accordance with NA.I.C. annual statement instructions handbook and follow N.A.I.C. accounting practices and procedures manual. The Commissioner may require information to be submitted to the agency in a computer-readable form compatible with the agency's electronic data processing system.

Inclusion of Ocean Marine Insurance: The exclusion of Ocean Marine insurance from the reinsurance and limit of risk mandates is removed.

House Bill 2462 – (continued)

Reciprocity: No domestic company shall transact insurance in any "reciprocal" state in which it is not properly licensed to transact insurance. Reciprocal state means a state which has in effect a similar prohibition against insurance companies domiciled in that state. This section does not apply to: (1) contracts entered where the prospective insured is personally present in the state in which the insurer is authorized when the application is signed; (2) issuance of certificates under group life or disability policy, where the master policy was entered into a state in which the insurer was then authorized; and (3) insurance covering risks or persons located in a reciprocal state, under contracts solicited and issued in states in which the insurer is then licensed.

Property Valuation: The value of real property held or acquired by an insurer is subject to the approval of the Commissioner. The Commissioner may, at his discretion, have the insurers property appraised by a licensed real estate appraiser. The expense of the appraisal is paid by the insurer. No insurer may hereafter increase the valuation of any real properties unless increased valuation is likewise approved by the Commissioner.

The applicability of this statute is extended to include the following entities: farmers mutuals, fraternal benefit societies, service corporations, health care corporations and health maintenance organizations.

Secondary Mortgage Market: The Commissioners authority is established to limit insurers abilities to invest in the secondary mortgage market. Domestic insurers are restricted from exercising the investment authority previously granted in section 106(a)(1) or (2) of the Secondary Mortgage Market Enhancement Act passed by the United States Congress in 1984

The applicability of this statute is extended to include health care corporations.

Rehabilitation and Liquidation: This section of the Code formerly acknowledged the terms "impairment" and "insolvency" as being interchangeable. This section is amended to distinguish between the two financial situations. "Impairment" means a situation in which the assets of an insurer are less than the sum of all its liabilities and required reserves including required minimal capital and surplus so as to maintain its authority to transact business.

"Insolvency" means a financial situation in which the assets of the insurer are less than the sum of all its liabilities and required reserves.

The applicability of the statute is extended to include health care corporations.

Service Corporations: (This includes hospital service corporations, such as Blue Cross/Blue

House Bill 2462 – (continued)

Shields; medical service corporations; dental service corporations and health care service corporations.)

The thirty day (30) deem period in which the Commissioner has to license one of these entities is eliminated.

If the Commissioner finds a service corporation impaired, he may issue orders and require the company to cure the impairment. Failure of the company to follow such actions indicates management incompetence and grounds for an order of rehabilitation or liquidation.

These corporations must maintain a statutory surplus of at least two million dollars (\$2,000,000), any company licensed prior to the effective date of this section, whose surplus is increased by virtue of this section, is required to maintain surplus of at least five hundred thousand dollars (\$500,000) after the effective date of this section. After October 1, 1991, any corporation shall be required to meet the full two million dollars (\$2,000,000) surplus requirement.

Special considerations solely given to service corporations regarding rehabilitation and liquidation proceedings under the current statutes are eliminated. By removing these exclusive provisions, the service corporations are treated identically to other domestic insurers when this agency seeks court action in placing companies in rehabilitation/liquidation.

The applicability of Article 35 (Criminal Sanctions) is extended to include these corporations. After October 1, 1991 these corporations are subject to Article 26A (West Virginia Life and Health Guaranty Association).

Health Care Corporations: These entities must have a surplus find of at least two million dollars (\$2,000,000). Corporations licensed prior to the effective date of this statute, whose requirements are increased by virtue of this section, have until January 1, 1994, to meet increased requirements.

The applicability of Article 35 (Criminal Sanctions) of Chapter 33 of the Code is extended to include service corporations.

Health Maintenance Organizations: The Commissioners time in which to issue or deny any persons filing an application to operate one of these entities is extended. The current time of sixty (60) days has been changed to one hundred and twenty (120) days.

These organizations must have fully paid in capital stock, if for a profit stock corporation, or statutory surplus, if a nonprofit corporation, of at least one million dollars (\$1,000,000). In addition, each HMO must maintain an additional surplus of at least one million dollars (\$1,000,000).

House Bill 2462 – (continued)

Any HMO licensed prior to the effective date of the section, whose capital and surplus requirements are increased due to this section, is required to maintain fully paid-in capital stock, if a for profit stock corporation, or statutory surplus funds, if a nonprofit corporation, of at least two hundred and fifty thousand dollars (\$250,000) and an additional two hundred and fifty thousand dollars (\$250,000) of surplus after January 1, 1992. Any HMO is subject to the full capital and surplus requirements of this section after January 1, 1994.

The applicability of Article 35 (Criminal Sanctions) of Chapter 33 of the Code is extended to include these organizations.

West Virginia Life and Health Guaranty Association: The scope of coverage for insureds serviced under this association has been restricted. All residents of West Virginia who are owners of or certificate holders of life, health and annuity policies are eligible.

Persons who are owners of or certificate holders under such policies and are not residents of West Virginia are only eligible when: (1) the company who issued the policies is domiciled in this state; (2) the company never held a C.O.A. in the state where the person resides; (3) the state where the person resides has an association similar to our guaranty association; and (4) the person residing in another state is not eligible for coverage by the association in that state.

Insurance Holding Company Systems: The Commissioners powers are strengthened to regulate certain transactions in which a domestic insurer and a person in its holding company system may enter. There are five specific incidences cited in which the insurer must notify the Commissioner before pursuing such measures. The insurer must notify the Commissioner in writing at least thirty (30) days before it can enter into these transactions.

The applicability of this statute has been extended to include the following entities: fraternal benefit societies, service corporations, health care corporations and health maintenance organizations.

Hazardous Financial Conditions: Twenty (20) standards have been established which the Commissioner may use to identify companies found to be in such condition that their continuation of business is hazardous to their policyholders and general public. If a company qualifies for one or more of these standards, the Commissioner can render it financially hazardous.

Ten (10) actions which the Commissioner may take when determining whether a company is financially hazardous are stipulated. They include: (1) reduce, suspend or limit the volume of business being accepted by the company; (2) increase the insurers capital and

House Bill 2462 – (continued)

surplus; and (3) refuse to recognize the stated value of accounts receivable.

The applicability of this statute applies to the following entities: farmers mutual companies, fraternal benefit societies, health care corporations, service corporations, health maintenance organizations, captive insurance companies, risk retention groups, stock insurers, mutual insurers and reciprocal insurers.

This legislation became **effective March 9, 1991.**

**House Bill 2789 -- Reporting of Professional Liability
Civil Actions on Medical Providers;
Tail Coverage**

This bill requires companies which provide professional liability insurance to a physician, osteopathic physician or surgeon, podiatrist or chiropractor to submit the following information on any judgment, dismissal or settlement of a civil action or claim to the Commissioner: 1) date of the judgment, settlement or dismissal; 2) whether any appeal has been taken and, if so, by which party; 3) the amount of any settlement or judgment against the insured and 4) any other information the Commissioner may require. Failure to report this information within thirty (30) days from the judgment, settlement or dismissal is subject to a civil money penalty imposed by the Commissioner.

This bill also defines and establishes mandates for tail insurance. This type of coverage applies to malpractice insurance which has been in effect for at least sixty (60) days to a medical physician, osteopathic physician, podiatrist, chiropractor, dentist, midwife or nurse practitioner. Upon cancellation, nonrenewal or termination of claims-made insurance, the insurer must offer tail insurance to those licensed individuals practicing in West Virginia. These insureds are to be given the opportunity to amortize premium payments over a period of no more than thirty-six (36) months in quarterly payments. These quarterly payments must not be less than seven hundred and fifty dollars (\$750). Any insurer who fails to offer tail insurance shall be assessed a penalty equal to the amount of the premium due.

This legislation becomes **effective June 6, 1991.**

House Bill 2801 -- Division of Consumer Advocacy

This bill creates a Division of Consumer Advocacy within the Insurance Commission. This division is authorized to deal with certain matters restrictively related to health insurance policies.

The Commissioner shall appoint a full-time director for a term of four (4) years to administer this division.

Consumer Advocacy is authorized to institute and intervene in court proceedings before administrative agencies and before the Health Care Cost Review Authority. This division may also advocate the interests of policyholders in proceedings for any filing made to the Insurance Commission by a company or relating to a complaint of unfair trade practice. Review and investigation of any policy regarding health care insurance rates through compiling data on reasonable and customary rate schedules of all health care providers is a further responsibility of this division.

All health insurance policies and subscriber contracts issued by service corporations, health care corporations and health maintenance corporations fall within the purview of this statute.

This legislation becomes **effective June 30, 1991.**

House Bill 2873 -- Payment of Unearned Premiums on Credit Life and Accident and Sickness Insurance

This bill establishes the Insurance Commissioners authority to promulgate regulations and prescribe the necessary forms in the matter of payment of any unearned premiums which an insurer must make to an insured upon his/her full payment of a loan for which this type of insurance was purchased.

This legislation becomes effective June 6, 1991.

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**House Bill 2901 -- Third Party Reimbursement for
Rehabilitation Services and Equal Treatment
to All Medical Providers**

This bill directs that on or after July 1, 1991, all individual and group accident and sickness policies must provide as benefits to all subscribers and members coverage for rehabilitation services unless so rejected by the insured.

This bill also mandates that any health insurance policy, plan or contract must be construed to include payment for covered medical services and treatments to all health care providers including: medical physicians, osteopathic physicians, podiatrists, chiropractors, midwives and nurse practitioners. Any limitation or condition placed upon services, diagnoses or treatment by, or payment to, any particular type of licensed provider shall apply equally to all licensed providers. The applicability of this section extends to service corporations, health care corporations and health maintenance organizations.

This legislation becomes **effective June 6, 1991.**