STATE OF WEST VIRGINIA

Offices of the Insurance Commissioner

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WEST VIRGINIA INFORMATIONAL LETTER

NO. 169

TO: All Insurance Companies Doing Business in the State of West Virginia, Insurance Trade Associations, Insurance Media Publications and Other Interested Persons

RE: Summary of 2009 Legislation

This Informational Letter summarizes significant insurance legislation enacted during the 2009 Regular Session of the West Virginia Legislature. It does not necessarily include all legislation that may affect the insurance industry or insurance consumers and is only intended to highlight the major points in the more important bills. The explanations contained herein should in no way be construed as being indicative of the Insurance Commissioner's views on or interpretation of the legislation.

The bills are available on the Legislature's website at www.legis.state.wv.us. The rules can be found on the Insurance Commissioner's website at www.wvinsurance.gov or the Secretary of State's website at www.wvsos.com.

BILLS

Senate Bill 278 - Creating felony offense for willful failure to provide certain drug benefits. (Effective July 10, 2009)

This bill amends W. Va. Code §33-15E-15 to clarify the criminal provisions in the discount medical/prescription plan act enacted in 2008. In the original legislation, determination of whether the crime of failing to provide promised benefits to plan members was a misdemeanor or a felony was based on the "value of the benefits denied" to the member. The bill amends this language to tie the misdemeanor/felony distinction to the amount of fees paid by the member. Now, if a person collects a fee for purported membership in a discount medical plan or discount prescription drug plan and knowingly and willfully fails to provide the promised benefits, he or she is guilty of a felony if the fees collected total $1,000 or more and a misdemeanor if less than $1,000.

Senate Bill 284 - Relating to Viatical Settlements. (Effective July 6, 2009)

This bill amends the Viatical Settlements Act that was initially enacted in 2008. The first change allows applicants for a broker's license to demonstrate evidence of financial responsibility through an errors and omissions policy in the sum of not less than $100,000 per occurrence and $300,000 in the aggregate for all occurrences within one year; the 2008 statute required an applicant to provide a surety bond in the amount of $250,000.

The second change corrects a drafting error in the criminal provisions of the Act in which only a viator (policyholder) could be convicted of a fraudulent viatical settlement act; the bill expands the scope of the criminal provisions to any "person convicted of a fraudulent viatical settlement act."

Senate Bill 322 - Exempting certain life insurance policies from Medicaid assignment. (Effective July 10, 2009)

Submission of an application to the state Department of Health and Human Resources ("DHHR") for medical assistance constitutes an assignment of the right of the applicant to recover from personal insurance or other sources to the extent of the cost of medical services paid by the Medicaid program. The bill exempts life insurance policies with a death benefit of $25,000 or less from this assignment.

Senate Bill 326 - Mandating certain dental anesthesia insurance coverage. (Effective July 10, 2009)

This bill mandates that most group and individual health insurance policies, including PEIA, cover general anesthesia for certain dental procedures performed on young people or those with certain developmental disorders.

Senate Bill 408 - Relating to model health plan for uninsurable individuals. (Effective July 8, 2009)

This bill permits the use of surplus funds in the Model Health Plan for Uninsurable Individuals fund (the State's high risk pool, commonly known as "AccessWV") to subsidize premiums of low-income enrollees. The AccessWV Board of Directors must propose legislative rules to establish eligibility criteria for applicants for the subsidies.

Current law imposes a six-month preexisting-condition exclusion on all new enrollees except those coming from a COBRA plan. The bill grants rulemaking authority to the AccessWV Board to propose additional classes of individuals to which the preexisting-condition exclusion would not apply.

Senate Bill 414 - Creation of the Governor's Office of Health Enhancement and Lifestyle Planning. (Effective August 26, 2009)

This bill terminates three existing programs – the prescription benefit program established in 2000; the 2004 pharmaceutical programs (cost management council, etc.), and the Interagency Health Council – and creates in their stead a new agency, the Governor's Office of Health Enhancement and Lifestyle Planning ("GO HELP"), the primary task of which is to "coordinate all state health care system reform initiatives" among all executive agencies. The bill also mandates that the GO HELP director implement four "medical home" pilots in addition to similar pilots now underway through the Bureau for Medical Services ("BMS") and PEIA.

Senate Bill 431 - Providing in-state medical providers notice of small group health benefit plan. (Effective July 6, 2009)

Under legislation enacted in 2004, unless a provider affirmatively notified PEIA that the provider would not accept PEIA's reimbursement rates under the small business plan (W. Va. Code §33-16D-16), such rates had to be accepted by that provider from any carrier participating in the plan. The original legislation had required notices of the opt-out opportunity to be sent to all known in-state health care providers by PEIA, and the bill now imposes this duty on the West Virginia Health Care Authority.

Senate Bill 434 - Relating to long-term care policy insurance agents. (Effective July 1, 2009)

This bill, which is based on a National Association of Insurance Commissioners ("NAIC") model, imposes new training requirements for insurance producers (agents) who sell long-term care ("LTC") policies. Every producer must complete 8 hours of training before selling such products and 4 hours in each biennium thereafter; producers selling such products on July 1, 2009, have a year to complete the initial 8-hour requirement. Companies must retain records of the training for 5 years. If West Virginia participates in the federal LTC Partnership program in the future, the training required by this legislation must be approved by the Commissioner.

Senate Bill 494 - Authorizing Insurance Commissioner to order restitution in certain cases. (Effective July 9, 2009)

This bill amends W. Va. Code §33-2-11 to clarify that the Commissioner may, in addition to other penalties or remedies available, order restitution to persons injured by insurance companies or producers. The bill provides that this restitution authority specifically applies to orders entered as a result of a financial or market conduct examination of any person "transacting the business of insurance in this state" and to orders entered after notice and hearing regarding a violation of any provision of the insurance code.

Senate Bill 495 - Authorizing Insurance Commissioner to permit certain groups life insurance policies. (Effective July 9, 2009)

This bill, which is based on an NAIC model act, amends the article on group life insurance that limited the types of groups eligible for group life policies to labor union groups, employee groups, credit union groups, trustee groups and debtor groups. This amendment gives the Commissioner discretion to authorize group policies to be marketed to any other group if she finds that it would be in the public's best interest to do so.

Senate Bill 537 - Relating to Workers' Compensation. (Effective July 10, 2009)

In addition to numerous technical changes, the bill makes the following substantive amendments to the Workers' Compensation statutes.

§23-2-1d. Prime Contractors and Subcontractors Liability - The amendment of this section (which had sunsetted) now holds prime contractors liable for providing workers' compensation benefits to an uninsured subcontractor's employees if that prime contractor had failed to require the subcontractor to produce a certificate of coverage.

§23-2A-1. Subrogation; limitations - This amendment clarifies some confusion about subrogation rights arising out of injured workers' claims against third-party tortfeasors.

--For any claim arising on or after January 1, 2006, a private carrier or self-insured employer is allowed statutory subrogation for both indemnity and medical benefits paid.

--For any claim arising before January 1, 2006, the Commissioner or BrickStreet is allowed statutory subrogation for only medical benefits paid through the date of recovery and (resurrecting the pre-2003 rule), with respect to any recovery arising out of a cause of action accruing prior to July 1, 2003, the Insurance Commissioner's or self-insured employer's recovery may not exceed 50% of the amount received by the injured worker.

--A new subsection was added giving the Commissioner the right to statutory subrogation for indemnity and medical benefits paid from the Uninsured Employers' Fund ("UEF") regardless of the date on which the cause of action arose.

--The amendments also allow the Insurance Commissioner to negotiate the amount to accept as subrogation.

§23-2C-8. Workers' Compensation Uninsured Employers' Fund - The change to this section confers jurisdiction on the Office of Judges ("OOJ") to hear protests on initial decisions to accept or reject a claim into the UEF rather than the bifurcated process in which the Commissioner determined whether the claim belonged in the UEF and OOJ determined, often contemporaneously, other claims-related issues.

§23-2C-15. Mandatory coverage - This changes the date -- from June 30, 2012 to June 30, 2010 -- on which state and local governmental bodies are able to purchase workers' compensation insurance from insurers other than BrickStreet. It also prohibits BrickStreet from cancelling or refusing to renew a policy of a state or local governmental body prior to July 1, 2011, except for nonpayment of premium or refusal to comply with a premium audit.

§23-2C-17. Administration of a competitive system - The amendment to subsection (c) clarifies that private carriers or self-insured employers may only enter into contracts with third party administrators that are licensed by OIC.

§23-2C-21. Limitation of liability of insurer or third-party administrator; administrative fines are exclusive remedies - This clarifies that the Commissioner has the authority to use all of her regulatory authority in Chapters 23 *and* 33 with respect to administrative fines and remedies against workers' compensation insurers. A change was also made to permit OOJ to award attorney's fees for an unreasonable denial of *any* TTD benefits; the prior law had been limited to denials of *initial* TTD awards only.

§23-4-1c. Payment of temporary total disability benefits directly to claimant; payment of medical benefits; payments of benefits during protest; right of commission, successor to the commission, private carriers and self-insured employers to collect payments improperly made -- Subdivision (a)(3) had previously permitted an expedited hearing for only an initial denial of TTD benefits; now, a claimant may request an expedited hearing for *any* denial of TTD benefits.

§23-4-6b. Occupational hearing loss - This change makes allocation of hearing loss claims among chargeable employers permissive rather than mandatory, which is consistent with the rule on allocation among employers in occupational disease ("OD") and occupational pneumoconiosis ("OP") claims.

§23-4-8. Physical examination of claimant - Whenever a claimant is ordered to appear for examination by the Occupational Pneumoconiosis Board or ordered to attend an Independent Medical Examination, the claimant must be reimbursed for lost wages and reasonable traveling expenses; if the travel is for any other type of medical treatment, including visits to his or her authorized treating physician, the claimant is entitled to reimbursement for reasonable traveling expenses only. A new subsection (e) defines "reasonable traveling expenses" as including reimbursement for meals, lodging and mileage; reimbursement for travel in a personal motor vehicle will be at the mileage reimbursement rates contained in the Governor's travel rules for state employees in effect at the time the treatment is authorized; these rates can be found at http://www.state.wv.us/admin/purchase/travel/.

§23-4-8d. Occupational pneumoconiosis claims never closed for medical benefits - A new section now provides that a request for medical services, durable medical goods or other medical supplies in an OP claim may be made at any time.

§23-5-1. Notice by commission or self-insured employer of decision; procedures on claims; objections and hearing - Under the prior law, every claimant had to be given a brochure explaining the claims process before an initial decision was made in the claim. The bill changes this to require that the brochure has to be sent only to claimants in OP and OD claims as well as in any claim in which temporary total benefits are being sought.

Under prior law, a claims administrator had to pay conditional benefits if the *only* controversy relating to compensability was whether an application for benefits was properly filed as a new claim or a reopening of a previous. The amended language now requires conditional payments whenever the protest simply includes such a controversy.

Subsection (c) is renumbered to clarify that the OOJ has jurisdiction generally to designate a new application as a reopening petition or vice versa or to reassign a claim from one insurer or self-insured employer to another whenever appropriate.

§23-5-16. Fees of attorney for claimant; unlawful charging or receiving of attorney fees - A new subsection (b) now provides that in a final settlement, an attorney cannot charge a fee in excess of 20% of the total value of the medical and indemnity benefits. The amendment further limits the attorney's fee by stating that the fee, when combined with any fees previously charged or received by the attorney for permanent partial disability or permanent total disability, may not exceed 20% of an award of benefits to be paid during a period of 208 weeks.

§33-2-22. Authority of Insurance Commissioner regarding employers in default to workers' compensation funds; injunctions against defaulting employers - This amendment grants the Commissioner the authority to compromise and settle claims for monies due to the Old Fund or the UEF. Information regarding such settlements is subject to FOIA, and the Commissioner must file an annual report that describes the parties involved in each settlement, the total amount owed/paid and the terms of the settlement.

Senate Bill 552 - Affordable health insurance plan proposals. (Effective April 11, 2009)

This bill requires the Commissioner to invite insurers to submit Affordable Health Care Plan proposals for OIC approval. These proposed plans, which can provide group or individual coverage; must provide cost containment through caps or co-pays, and every proposal must include at least one plan offering catastrophic coverage. In order to reduce the cost of these plans, many mandated benefits are eliminated. OIC will assist in the marketing of approved plans.

As a response to the American Recovery and Reinvestment Act of 2008, the bill includes a provision that makes unemployed persons who were involuntarily terminated from jobs between September 1, 2008 and February 17, 2009, but who either did not elect COBRA coverage or who elected such coverage but had thereafter terminated it, a second chance to elect COBRA coverage and thus take advantage of federal subsidies. The bill required employers to send this "second-opportunity" notice by April 18, 2009, giving the affected former employees 60 days to make the election to continue COBRA group coverage with a 65% premium subsidy from the federal government.

Senate Bill 632 - Requiring insurers share certain information with Bureau for Medical Services. (Effective July 7, 2009)

This bill requires insurers to share information with the BMS regarding claims that may have been paid by BMS during a period when an individual was covered by private insurance.

Senate Bill 669 - Extending Preventive Care Pilot Program. (Effective July 8, 2009)

This bill extends the Preventative Care Pilot Program for two years and increases the number of parties allowed to participate. The bill also requires the Insurance Commissioner to propose a legislative rule regarding limited participation by a subscriber or employer with a high-deductible health benefit plan. The rule must further require notice to a subscriber or employer that, depending on the policy, payment for prepaid health services may or may not count towards an applicable health insurance deductible.

House Bill 2660 - Expanding the definition of limited health care service. (Effective July 10, 2009)

This bill authorizes the creation of additional classes of prepaid limited health service organizations formed pursuant to W. Va. Code §33-25D-1 *et seq*., which had been limited to such organizations offering mental or behavioral health services. The bill expands the definition of "limited heath service" to include dental, vision, podiatric and pharmaceutical services, including Medicare Part D prescription drug plans. The primary focus for the bill is to create an additional licensing vehicle for qualifying Medicare Part D prescription drug plans. Under the new Medicare program, carriers offering the Part D prescription coverage must be licensed in the states in which they operate as risk bearing entities, which meant often having to meet solvency requirements intended for larger accident and sickness insurance companies. The bill is consistent with the NAIC's amendment of its model Prepaid Limited Health Service Organization Act.

House Bill 2757 - Relating to financial audits of insurers. (Effective July 7, 2009)

The NAIC conducts an accreditation review in each state every five years to assure that each accredited state has sufficient authority to regulate the solvency of its domestic industry. This bill, which was proposed to meet recent NAIC accreditation mandates, makes several changes to West Virginia's audit rules. These changes involve attempts to increase auditor independence by limiting how often a lead auditor may serve in such a capacity and by prohibiting an auditor from serving a company if he or she provides non-auditing services to that company. The changes also attempt to increase the level of corporate governance by requiring the company to have an audit committee to oversee auditing services and to file a report with the OIC regarding their assessment of internal controls over financial reporting, which report must include management's assessment of the effectiveness of these internal controls and disclose any unremediated material weaknesses. The corporate governance changes are only mandated for companies with more than $500,000,000 in annual direct premiums in West Virginia; at present, this would affect only Mountain State BCBS and BrickStreet.

House Bill 2884 - Long-Term Care Partnership Program. (Effective July 10, 2009)

This bill mandates that the state Medicaid agency propose amendments to the State Plan that would establish a public/private state LTC partnership program in West Virginia. The federal partnership program was developed in the 1980s to encourage the purchase of LTC insurance by permitting persons who purchase qualifying policies to retain a specified amount of assets and still qualify for Medicaid for the payment of LTC services.

House Bill 2885 - Establishing a uniform credentialing form and creating a single credentialing verification organization. (Effective July 10, 2009)

The Uniform Credentialing Advisory Committee ("UCAC") was established in 2001 to create uniform forms for credentialing health care providers and to assist in promulgation of joint rules with OIC and DHHR regarding the forms. The bill expands the mandate of the UCAC's advisory committee to include consideration of the establishment of one or more credentialing verification organizations within the state to provide primary source verification. DHHR and OIC must report to the Legislature by January 1, 2010 on proposed legislation to implement the provisions of the bill.

House Bill 3047 - Clarifying that the Director of the Public Employees Insurance Agency is authorized to enter into capitated provider arrangements for provision of primary health care services. (Effective July 10, 2009)

This bill adds capitated primary care arrangements to the preferred provider system that the section authorizes PEIA to establish for the delivery of health care to PEIA plan participants. It also provides that such arrangements are not subject to regulation by OIC.

House Bill 3278 - Relating to the life and health insurance guaranty association. (Effective July 10, 2009)

The bill updates the Life and Health Guaranty Fund Association Act by adopting recent amendments to the NAIC model. These changes include the inclusion of unallocated annuity contracts and structured settlement contracts; addresses how payments to residents and nonresidents are determined; sets new limits on coverage for various types of policies and contracts; eliminates the Association's authority to make loans to insolvent insurers; increases the permissible maximum annual pro rata assessment and establishes a process for the protest of assessments; mandates that members comply with requests for information from the association; requires that the plan of operation include provisions for removing a director for cause; addresses conflicts-of-interest issues; and increases the length of the stay of court proceedings involving an insolvent insurer.

House Bill 3288 - Relating to mental health parity. (Effective August 25, 2009)

This bill makes essentially technical changes necessary to comply with recent federal law changes with respect to mental health parity. In addition to changing the way in which parity is measured – actual costs of mental health benefits relative to medical/surgical benefits, instead of the anticipated costs of such benefits – the bill removes the distinction between small and large groups for purposes of parity.

LEGISLATIVE RULES

Senate Bill 227 - Authorizing the Department of Revenue and the Insurance Commissioner to promulgate legislative rules.

114 CSR 32 - Long-Term Care (amended rule effective July 1, 2009)

This major revision conforms the rule to the NAIC's 2006 amendments to its Model Regulation 641. As amended, the rule provides a comprehensive scheme for regulating LTC insurance by adding provisions to address the following: Unintentional lapses; required disclosure of rating practices; initial filing requirements; premium rate schedule increases; notice to the policyholder of the availability of new services or providers; right to reduce coverage and lower premium; and standards for benefit triggers. The amendments also change the reporting requirements imposed on insurers, adopts new loss ratio standards, and changes the standards for marketing. The existing section governing insurers' efforts to determine the appropriateness of the recommended purchase or replacement is greatly expanded.

114 CSR 41 - Actuarial Opinion and Memorandum Rule (amended rule effective May 14, 2009)

The amendments to this rule, which mirror the changes in 2001 by the NAIC to its actuarial opinions model, are needed to maintain the NAIC accreditation that permits West Virginia's financial examinations to be accepted in other accredited states.

114 CSR 42 - Continuing Education for Individual Insurance Producers (amended rule effective May 14, 2009)

In 2008, the Legislature enacted H.B. 4557 to permit up to two hours of continuing education ("CE") credit every biennium for active membership in an organization or association recognized and approved by the Commissioner as a state, regional or national professional insurance organization or association. The bill also permitted the carryover of up to six CE credit hours to the following biennium. This rule implements these statutory changes and also establishes standards by which the Commissioner assesses whether applicant organizations qualify for membership credit.

114 CSR 80 - Viatical Settlements (new rule effective May 14, 2009)

This new rule, which regulates providers and brokers involved in the life settlement ("viatical") industry, is largely based on a model regulation adopted by the NAIC in 2004. The rule addresses licensing requirements, standards for reasonable payments to terminally or chronically ill insureds, annual reporting requirements and payment of settlements.

114 CSR 83 - Discount Medical Plan Organizations and Discount Prescription Drug Plan Organizations (new rule effective May 14, 2009)

This new rule implements 2008 legislation that subjected discount medical and prescription plan organizations to regulation by OIC. The rule addresses licensing, marketing, fees, consumer protections, record retention and sanctions.

114 CSR 85 - Professional Employer Organizations (new rule effective May 14, 2009)

This new rule implements a 2008 bill regulating professional employer organizations ("PEOs"). The rule establishes procedures for licensing of professional employer organizations or professional employer organization groups and establishes standards which a professional employer organization or professional employer organization group must meet when conducting business in the State of West Virginia.

114 CSR 86 - Preneed Life Insurance Minimum Standards for Determining Reserve Liabilities and Nonforfeiture Values (new rule effective May 14, 2009)

Actuarial research has determined that the 2001 CSO Mortality Table, currently recognized as the prevailing table for the purposes of calculating reserves and nonforfeiture values both on a statutory basis and on a tax basis, produced inadequate reserves for policies issued in support of a prearrangement agreement to provide goods and services at the time of an insured's death. This rule requires the use of the 1980 Commissioners Standard Ordinary (CSO) Life Valuation Mortality Table for use in determining the minimum standard of valuation of reserves and the minimum standard nonforfeiture values for preneed insurance products issued after January 1, 2012; prior to that date, the 2001 CSO table may be used if certification of adequate reserves is filed.

If you have any questions concerning this Informational Letter, please e-mail your question(s) to Informational.Letters@wvinsurance.gov or call (304) 558-0401.

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