

West Virginia *Offices of the* Insurance Commissioner



Accident and Health Insurance 2022 Market Report

July 17, 2023

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I. INTRODUCTION

Featured in this report is a comparison between the 2022 and 2021 health insurance markets. The market is a continual paradigm of change since the passage of the Patient Protection and Affordable Care Act (PPACA), commonly referred to as the Affordable Care Act (ACA). This report will provide an overview of the ACA and other lines of private health and accident insurance that are regulated by the West Virginia Offices of the Insurance Commissioner (WVOIC).

There are two basic types of Health Insurance Coverage: private and public. Private health insurance is offered by insurance companies to individuals and businesses. Public health insurance is offered by government agencies to public employees, lower income individuals, and the elderly population. The WVOIC regulates Private Health Insurance, except group self-insured plans. The group self-insured plans are regulated by the Federal Government under The Employee Retirement Income Security Act of 1974 (ERISA). ERISA preempts state laws and regulations in most scenarios.

II. COMPREHENSIVE MAJOR MEDICAL COVERAGE

The Patient Protection and Affordable Care Act

The ACA was signed into United States federal law on March 23, 2010. The law introduced mandates, subsidies, and insurance marketplaces. The ACA requires insurance companies to cover all applicants within minimum standards and offer rates regardless of pre-existing conditions or gender.

Some of the significant reforms of the ACA are:

- Guaranteed issue – prohibits insurers from denying coverage to individuals due to pre-existing conditions, and it requires insurance companies to offer the same premium price to all applicants of the same age and geographical location without regard to gender. The only condition a policy can be additionally rated for is tobacco use.
- Essential Health Benefits (EHBs) for insurance policies are established. The ten benefits include:
 - ~ Ambulatory patient services
 - ~ Emergency services
 - ~ Hospitalization
 - ~ Maternity and newborn care



- ~ Mental health and substance use disorder services, including behavioral health treatment
 - ~ Prescription drugs
 - ~ Rehabilitative and habilitative services and devices
 - ~ Laboratory services
 - ~ Preventative and wellness services and chronic disease management
 - ~ Pediatric services, including dental and vision care (pediatric oral services may be provided by a stand-alone plan)
- Policies having the EHBs and meeting the other guidelines of the ACA are called “Qualified Health Plans” (QHPs).
 - Advanced Premium Tax Credits (APTC) can be received to help individuals pay their health insurance premium. The APTC can be available to individuals and families whose incomes are between 100% and 400% of the federal poverty level (FPL), and they can enroll at www.Healthcare.gov. The FPL changes annually before open enrollment.
 - People eligible for APTCs may also be eligible for cost-sharing reductions (CSRs). The CSRs are available to people with a household income up to 250% of the poverty level. The CSRs reduce the out-of-pocket maximum by lowering the deductible and co-payments only on a Silver plan. A Silver plan is one of the four metal levels: Platinum, Gold, Silver and Bronze. The Silver plans are the most common choice of Marketplace shoppers. They have a moderate monthly premium and moderate costs when you need care.
 - Dependents, regardless if married, a student, or no longer living with their parents, are eligible to remain on their parents’ insurance until the age of 26.
 - Insurance companies cannot impose a lifetime dollar limit on EHBs. Insurance companies are prohibited from charging co-payments, co-insurance, or deductibles for preventative care with a Level A or B rating from the United States Prevention Services Task Force (USPSTF).
 - An employer mandate is in effect for businesses employing fifty or more full-time equivalent employees. If the business does not offer health insurance or does not offer affordable health insurance and their employees buy health insurance and receive an APTC, then the business will pay a tax penalty.

Partnership State

West Virginia is a “Partnership State”, meaning that the State has chosen to take on the functionalities of Consumer Assistance (education and outreach) and Plan Management (policy form and rate approval) related to the Marketplace.

As a Partnership State, West Virginia consumers experience “The Marketplace” as an online portal at www.Healthcare.gov to compare information on available health plan options, enroll in health plans, and receive APTCs and CSRs, if financially eligible.

Consumer Assistance

The Consumer Assistance function required the State to develop an In-Person Assistance (IPA) Program to help individuals with the enrollment process. Although the formal program is no longer funded, trained in-person assistance through Certified Application Counselors (CAC) can be found in local Federally Qualified Health Centers, hospitals and some community organizations. The federal government continues to fund the Navigator Program for in-person assistance. West Virginia has a statewide navigator, First Choice Services. The assister/navigator service is impartial and free to consumers. In addition, licensed health insurance agents and brokers may enroll individuals, small employers, and employees in coverage. Federal and state training and certification requirements apply to agents, brokers, navigators, and CACs who enroll or assist consumers in the Marketplace.

The OIC has a Consumer Services Division that is available to help consumers with questions or complaints about their health insurance, plus any other type of insurance a consumer may have. They may be contacted at 1-888-879-9842 or OICConsumerServices@wv.gov. You may view additional information on our website at: <https://www.wvinsurance.gov/>.

Plan Management

West Virginia is a prior approval state. A prior approval state requires insurance companies to file their rates, forms, rules, and advertising and receive approval from the state before implementing. W. Va. Code §33-6-8, 33-15-1b & 33-16B-1, is the primary authority for West Virginia to review and recommend Qualified Health Plans (QHPs) for certification.



West Virginia Marketplace Enrollment

The ACA only allows enrollment during the Open Enrollment Period (OE) for each plan year, unless an individual has a qualifying event that allows for a “Special Enrollment Period” (SEP). The Open Enrollment Period runs from November 1 to December 15 annually.

West Virginia has two insurance companies offering plans on the Marketplace: CareSource and Highmark West Virginia.

Shown in the following chart are the enrollment numbers for individuals that enrolled directly through Healthcare.gov for a Marketplace Plan in West Virginia.

	2022	2021	2020	2019	2018	2017	2016	2015	2014
Received Advanced Premium Tax Credits (APTC)	94%	90%	87%	88%	86%	84%	88%	87%	87%
Received Cost Sharing Reduction (CSR) Payments*	37%	47%	46%	48%	55%	59%	52%	54%	56%
Did not receive premium assistance	6%	10%	13%	12%	14%	16%	12%	13%	13%
Total Enrollment	23,037	17,217	20,066	22,599	27,409	34,045	37,284	33,421	19,856

* All that received CSRs also received APTCs

West Virginia expanded their Medicaid program under the ACA. This has increased the number of West Virginians on Medicaid by approximately 160,000. Medicaid is regulated by the West Virginia Department of Health and Human Resources. For more information about Medicaid and the West Virginia expansion, please click [here](#).



Shown in the following tables are Care snapshots of the Health Insurance Market in 2022. The top 10 insurance carriers are listed for each line of health insurance (if at least ten insurance companies offered coverage in the year illustrated).

The National Association of Insurance Commissioners (NAIC) *Group Code* is the code for the parent company, and the NAIC *Company Code (CoCode)* is the code for the company writing business.

Earned premium is the portion of the insured's premium allocated to the insurance company's loss experience, expenses, and profit at yearend. If the amount is negative, the company did not profit in this line of business.

Covered lives are the total number of lives insured, including dependents under an individual policy and group certificates as of the yearend. If the amount is zero, then no policies were written in that year, only premiums or expenses were calculated.

Other(s) is the total number of other insurance companies writing business not listed in the top 10.

Individual Comprehensive Major Medical

2022 Top 10 Carriers of Individual Major Medical				
Group Code	Cocode	Name	Health Premium Earned	Number of Covered Lives
812	54828	Highmark West Virginia Inc.	\$ 218,112,425.00	14,630
3683	15728	CareSource WVA Co	\$ 84,079,036.00	8,657
707	62286	Golden Rule Ins Co	\$ 3,557,684.00	497
1297	95677	The Hlth Plan of WVA Inc	\$ 1,226,989.00	76
241	65978	Metropolitan Life Ins Co	\$ 65,254.00	19
408	71773	American Natl Life Ins Co of TX	\$ 49,740.00	8
408	86355	Standard Life & Accident Ins Co	\$ 34,161.00	16
1	60054	Aetna Life Ins Co	\$ 29,063.00	-
707	79413	UnitedHealthcare Ins Co	\$ 7,487.00	-
	11121	Unified Life Ins Co	\$ 6,841.00	4
		Other 75 Companies	\$ 1,337.00	2
			\$ 307,170,017.00	23,909



Small Group Comprehensive Major Medical

2022 Top 10 Carriers of Small Group Major Medical				
Group Code	Cocode	Name	Health Premium Earned	Number of Covered Lives
812	54828	Highmark West Virginia Inc.	\$ 216,342,140.00	25,170
707	79413	UnitedHealthcare Ins Co	\$ 18,404,544.00	1,729
1297	95677	The Hlth Plan of WVA Inc	\$ 7,790,683.00	768
1297	60016	THP Ins Co	\$ 3,045,141.00	287
707	96940	Optimum Choice Inc	\$ 703,661.00	104
1	60054	Aetna Life Ins Co	\$ 151,643.00	61
		Other 85 Companies	\$ -	-
			\$ 246,437,812.00	28,119

Large Group Comprehensive Major Medical

2022 Top 10 Carriers of Large Group Major Medical				
Group Code	Cocode	Name	Health Premium Earned	Number of Covered Lives
812	54828	Highmark West Virginia Inc.	\$ 828,962,706.00	103,778
1297	95677	The Hlth Plan of WVA Inc	\$ 90,555,142.00	18,813
707	79413	UnitedHealthcare Ins Co	\$ 14,325,284.00	1,855
901	67369	Cigna Hlth & Life Ins Co	\$ 10,444,001.00	1,284
1	60054	Aetna Life Ins Co	\$ 9,713,284.00	1,460
1297	60016	THP Ins Co	\$ 5,414,081.00	734
1	95109	Aetna Hlth Inc PA Corp	\$ 2,221,521.00	291
707	96940	Optimum Choice Inc	\$ 1,089,708.00	96
		Other 85 Companies	\$ -	-
			\$ 962,725,727.00	128,311



III. PUBLIC EMPLOYEES INSURANCE AGENCY (PEIA)

The West Virginia PEIA was established under the Public Employees Insurance Act of 1971 to provide hospital, surgical, group major medical, prescription drug, group life, and accidental death and dismemberment insurance coverage to eligible employees; and to establish and promulgate rules for the administration of these plans. Benefits are made available to all active employees of the State of West Virginia and various related State agencies and local governments. Participants may elect health insurance coverage through a fully self-insured preferred provider benefit plan (PPB) or through external managed care organizations (MCO). For revenue, PEIA relies almost solely on the premiums paid directly by its participating employers and employees.

Type of Plan	2021 Covered Lives	2022 Covered Lives
PEIA PPB Plan	164,797	162,700
PEIA Managed Care with a Private Insurance Plan	15,042	14,958
PEIA Retirees on Medicare Advantage Plans	52,173	52,242
Total Lives Covered on all Plans	232,012	229,900

IV. MEDICARE COVERAGE

Medicare is the national health insurance program for people age 65 or older, or under age 65 with disabilities and people with End-Stage Renal Disease (ESRD), which is permanent kidney failure requiring dialysis or kidney transplant. ***ONLY the Medicare Supplement is regulated by WVOIC.***

Medicare Part A is government-provided hospital insurance under Medicare that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care. There is usually no cost for Part A coverage; it is referred to as “Premium Free Part A”. If you are required to pay a premium for Part A, it can cost up to \$422 monthly. This may apply if you and your spouse have not worked or only paid into Medicare for a minimum number of quarters.

Medicare Part B is optional government-provided medical insurance under Medicare that helps cover medically necessary services like doctors’ services, outpatient care, durable medical equipment, home health services and other medical



services, along with some preventive services. Unlike Part A, Part B requires covered individuals to pay premiums.

Medicare Part C or Medicare Advantage is a private company alternative to the original Medicare plan. Medicare Advantage plans provide care under contract to Medicare. They may provide benefits like coordination of care or reducing out-of-pocket expenses. Some plans may offer additional benefits, such as prescription drugs. There are two types of Medicare Advantage plans: Medicare Managed Care Plan and Medicare Private Fee-for-Service plans.

Medicare Part D is optional prescription drug coverage under Medicare. Part D may be offered as a benefit under Medicare Parts A, B, or C or under a stand-alone private policy.

Medicare Supplement or Medigap Policy is a private sector health plan filling gaps in Medicare Part A and B coverage that arise from deductibles, copays, and exclusions. Medicare Supplement plans must meet one of a set of defined benefit schedules and only one plan may be sold to any individual. These plans are regulated both by the state and the federal government. Medicare Supplements are regulated under WV Code §33-16-3d and WV Code §33-28-5b.

For more information contact the Consumer Service Division of the West Virginia Offices of the Insurance Commissioner at (888) 879-9842 or The West Virginia State Health Insurance Assistance Program (SHIP) at (877) 987-4463, or your insurance agent or insurance company.



Medicare Supplement Policies

2022 Top 10 Carriers of Medicare Supplements				
Group Code	Cocode	Name	Health Premium Earned	Number of Covered Lives
707	79413	UnitedHealthcare Ins Co	\$ 85,702,190.00	30,787
812	54828	Highmark West Virginia Inc.	\$ 19,916,818.00	6,555
261	13100	Omaha Ins Co	\$ 13,685,120.00	4,429
261	72850	United World Life Ins Co	\$ 12,111,128.00	6,495
1	12321	American Continental Ins Co	\$ 11,050,936.00	6,645
1	68500	Continental Life Ins Co Brentwood	\$ 7,911,490.00	1,895
1	78700	Aetna Hlth & Life Ins Co	\$ 6,813,651.00	2,397
119	73288	Humana Ins Co	\$ 6,342,945.00	2,585
901	88366	American Retirement Life Ins Co	\$ 6,142,462.00	2,148
261	69868	United of Omaha Life Ins Co	\$ 6,043,127.00	1,347
		Other 92 Companies	\$ 14,170,527.00	6,652
			\$ 189,890,394.00	71,935

V. LONG-TERM CARE COVERAGE

Long-term care (LTC) insurance is different from medical or health insurance because it generally helps you to live as you live now instead of improving or correcting medical problems. This type of insurance will pay or reimburse you for some or all your long-term care costs. It was first introduced as nursing home insurance but now often covers services in other facilities, home health and care management services.

Longevity and persistency actuarial assumptions on early LTC products have proven to be very inaccurate. Insurers underestimated how long people would live. As it became apparent the actuarial longevity estimates were wrong, the solution of choice seemed to be to raise rates. Another assumption made by actuaries related to persistency – actuaries assumed many people would drop their coverage over time. This proved not to be the case, as dropping a policy meant the consumer would receive nothing in return for premiums paid. An additional unknown was the extent of the incidence of cognitive memory disorders such as Alzheimer’s disease. People can live for a long time with Alzheimer’s disease and similar memory challenges.



The NAIC has formed a task force focused on long-term care insurance market stability. While the West Virginia Offices of the Insurance Commissioner has worked closely with consumers and insurance companies for affordable options in long-term care insurance, this task force will provide a new opportunity to address critical issues related to long term care. West Virginia is an active participant with this task force.

The task force was formed to: 1) evaluate the sufficiency of actuarial valuation standards; 2) evaluate the sufficiency of current financial reporting; 3) assess regulatory considerations on rate increase requests on blocks of business to identify common elements for achieving greater transparency and predictability; and 4) consider product innovations and potential state and federal solutions for stabilizing the LTC market.

WVOIC regulates long-term care insurance under WV Code §33-15A. To learn more about Long-term care insurance please click [here](#) for the NAIC Shopper's Guide.

Individual Long-Term Care Exhibits

2022 Top 10 Carriers of Individual Long-Term Care					
Group Code	Cocode	Name	Health Premium Earned	Number of Covered Lives	
4011	70025	Genworth Life Ins Co	\$ 6,403,619.00	2,954	
860	69000	Northwestern Long Term Care Ins Co	\$ 4,970,475.00	1,630	
904	65838	John Hancock Life Ins Co USA	\$ 1,773,016.00	861	
241	65978	Metropolitan Life Ins Co	\$ 1,452,656.00	656	
233	61263	Bankers Life & Cas Co	\$ 1,431,709.00	842	
261	71412	Mutual of Omaha Ins Co	\$ 1,256,551.00	529	
4	65005	RiverSource Life Ins Co	\$ 895,020.00	417	
826	66915	New York Life Ins Co	\$ 876,702.00	383	
176	25178	State Farm Mut Auto Ins Co	\$ 869,288.00	431	
435	65935	Massachusetts Mut Life Ins Co	\$ 527,618.00	248	
		Other 74 Companies	\$ 778,431.00	551	
			\$ 21,235,085.00	9,502	



VI. OTHER HEALTHCARE INSURANCE PRODUCTS

Dental Insurance provides only dental coverage issued as stand-alone dental or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.

2022 Top 10 Dental Carriers in West Virginia				
Group Code	Cocode	Name	Health Premium Earned	Number of Covered Lives
2479	12329	Delta Dental of W VA	\$ 29,547,705.00	115,303
241	65978	Metropolitan Life Ins Co	\$ 15,035,448.00	44,413
812	54828	Highmark West Virginia Inc.	\$ 7,322,213.00	-
332	61271	Principal Life Ins Co	\$ 5,121,497.00	18,271
812	85766	United Concordia Ins Co	\$ 4,704,983.00	12,576
901	67369	Cigna Hlth & Life Ins Co	\$ 4,483,360.00	12,718
477	61700	Renaissance Life & Hlth Ins Co of Am	\$ 1,817,679.00	5,556
119	73288	Humana Ins Co	\$ 1,199,146.00	3,578
367	80578	Physicians Mut Ins Co	\$ 1,099,899.00	2,206
	61921	Citizens Security Life Ins Co	\$ 1,096,173.00	1,961
		Other 49 Companies	\$ 4,467,587.00	13,033
			\$ 75,895,690.00	229,615

Vision Insurance provides only vision coverage issued as stand-alone vision or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.

2022 Top 10 Vision Carriers in West Virginia				
Group Code	Cocode	Name	Health Premium Earned	Number of Covered Lives
241	65978	Metropolitan Life Ins Co	\$ 6,227,309.00	16,643
119	73288	Humana Ins Co	\$ 3,471,826.00	89,507
1189	39616	Vision Serv Plan Ins Co	\$ 3,114,418.00	41,467
812	54828	Highmark West Virginia Inc.	\$ 2,720,853.00	170
451	71870	Fidelity Security Life Ins Co	\$ 1,088,969.00	19,760
477	61700	Renaissance Life & Hlth Ins Co of Am	\$ 400,553.00	5,507
	61921	Citizens Security Life Ins Co	\$ 375,185.00	1,848
4696	53953	Vision Benefits of Amer Inc	\$ 151,386.00	3,832
3098	68381	Reliance Standard Life Ins Co	\$ 82,413.00	487
812	85766	United Concordia Ins Co	\$ 7,541.00	77
		Other 45 Companies	\$ 1,841,867.00	23,581
			\$ 19,482,320.00	202,879



Short Term Limited Duration Medical Plans

Short term medical plans are not comprehensive major medical. The plan is intended to provide consumers and covered dependents with some basic insurance coverage that is capped at a specific amount for specific services. This type of plan will not cover pre-existing conditions. These plans do not meet the requirements of the ACA.

For additional information on this type of plan, please review our [Qualified Health Plan versus Short-Term Plan Brochure](#).

Disability Income

Provides payment of income benefits when a person's income is reduced or eliminated because of an illness or injury incurred while the policy was in force. The benefit is in proportion to the amount of lost income or total policy benefit.

2022 Top 10 Disability Carriers in West Virginia (Long Term & Short Term)				
Group Code	Cocode	Name	Health Premium Earned	Number of Covered Lives
565	62235	Unum Life Ins. Co. Of America	\$ 13,971,727.00	24,087
860	67091	Northwestern Mut Life Ins. Co	\$ 11,344,488.00	10,087
20	65676	Lincoln Natl. Life Ins. Co.	\$ 10,984,851.00	83,152
826	65498	Life Ins. Co. of America	\$ 8,458,897.00	7,433
1348	69019	Standard Ins. Co.	\$ 7,379,530.00	30,817
91	70815	Hartford Life & Accident Ins. Co.	\$ 6,497,823.00	22,764
370	60380	American Family Life Asur. Co. of Col.	\$ 6,080,889.00	9,116
330	60410	American Fidelity Assur. Co.	\$ 4,515,278.00	7,602
241	65978	Metropolitan Life Ins Co	\$ 4,346,050.00	23,728
332	61271	Principal Life Ins. Co.	\$ 4,293,745.00	9,782
		Other 44 Companies	\$ 8,045,618.00	24,380
			\$ 85,918,896.00	252,948

Healthcare Sharing Ministries

The HCSM concept began in the Amish and Mennonite communities more than a century ago. HCSM is the concept of sharing medical needs and expenses among a group of individuals with the same religious beliefs. This has now expanded to groups that share the principles of individual responsibility for their own health and of helping others in need. The HCSMs are **not** insurance.



HCSM plans offer significantly fewer protections than ACA-compliant health insurance. The following are highlights of some plan features that are common among the HCSM plans.

- Plans have maximum dollar limits generally between \$125,000 and \$250,000 per incident.
- Prescription drugs are excluded.
- Preventative services excluded.
- Have a pre-existing condition exclusion.
- Have moral guidelines and may refuse to cover any claim that is in violation of the guidelines, including pregnancy outside of marriage and diseases related to alcohol or drug use.
- No formal appeal process for claim denials.
- Members are self-paid and must pay providers upfront then be reimbursed.
- HCSM policies do not guarantee payment of claims and are not insurance.

VII. 2022 SUMMARY OF HEALTH LEGISLATION

Senate Bill 291 – Relating to mental health parity (Effective June 5, 2020)

This legislation requires, for any insurance policy, contract, plan, or agreement that is issued or renewed after January 1, 2021, health insurance companies to provide parity regarding coverage for (1) behavioral health, mental health, and substance use disorders; and (2) medical and surgical procedures. The bill mandates that health insurers comply with federal regulations concerning financial requirements and quantitative treatment limitations and may not apply any nonquantitative treatment limitations to benefits for behavioral health, mental health, and substance use disorders that are not applied to medical and surgical benefits within the same classification of benefits. Applicable insurers must have procedures to authorize treatment with a nonparticipating provider if a covered service related to behavioral health, mental health, and substance use disorders is not available within established time and distance standards and within a reasonable period after service is requested. The same coinsurance, deductible, or copayment requirements apply as if the service was provided by a participating provider, and at no greater cost to the covered person than if the services were obtained from a participating provider.

114 CSR 99 - Pharmacy Auditing Entities and Pharmacy Benefit Managers

This rule is in response to Senate Bill 489 (2019). The purpose of the 2019 legislation was to provide for additional regulatory oversight of pharmacy benefit managers (PBMs). The legislation included provisions both permitting and requiring the OIC to promulgate rules to implement the provisions of the law. The adopted rule sets



forth requirements pertaining to licensing, fees, application, financial standards and reporting with respect to PBMs, as well as the penalties or fines concerning any violation of Senate Bill 489 or the rule for both PBMs and pharmacy auditing entities.

Senate Bill 787 – Relating to the provision of insurance coverage benefits to pharmacists for rendered care (Effective June 5, 2020)

This legislation requires insurance coverage for pharmacist care. More specifically, for health plans, policies, contracts, or agreements issued, amended, adjusted, or renewed on or after January 1, 2021, benefits may not be denied for any health care service performed by a pharmacist licensed under W. Va. Code §30-5-1 et seq. if: (1) The service performed was within the lawful scope of the pharmacist’s license; (2) The plan would have provided benefits if the service had been performed by another health care provider; and (3) The pharmacist is included in the plan’s network of participating providers. The bill further requires a health plan to include an adequate number of pharmacists in its network of participating health care providers.

House Bill 4061 – Relating to the Health Benefit Plan Network Access and Adequacy Act (Effective June 5, 2020)

This legislation enacts the Health Benefit Plan Network Access and Adequacy Act and requires the honoring of an assignment of certain benefits in dental care insurance programs. The bill requires a health insurer that maintains a network of health care providers for its insureds to ensure that the network is sufficient in numbers and has appropriate types of providers for all covered services to be accessible without unreasonable travel or delay. An insurer must file an access plan so that the Insurance Commissioner may evaluate the insurer’s network. The access plan must meet certain criteria set forth in the bill. Along with the access plan, an insurer must provide the Commissioner with sample contract forms proposed for use with its participating providers. If an insurer has an insufficient network, the insurer must have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits. Moreover, if it is determined that an insurer has not contracted with a sufficient number of participating providers to assure that covered persons have accessible health care services in a geographic area, the Commissioner shall require a modification to the access plan or institute a corrective action plan, as appropriate, that shall be followed by the insurer. The legislation further requires an insurer to electronically post a current and accurate provider directory, with available search functions, for each of its network plans. The provider directory should include certain information pertaining to the health care providers and facilities that are in the network. The legislation also provides that the responsibility required of insurers to monitor the offering of covered benefits to insureds may not be delegated or



assigned to an intermediary. The bill additionally states that an insurer which offers dental care coverage to a covered person must honor an assignment, made in writing by the person covered under the policy, of payments due under the policy to a dentist or a dental corporation for services provided to the covered person that are covered under the policy. Upon notice of the assignment, the insurer must make payments directly to the provider of the covered services. A covered person may revoke the assignment with or without the consent of the provider. The revocation is effective when both the insurer and the provider have received a written copy of the revocation notice. An insurer must provide conspicuous notice to the covered person that the assignment of benefits is optional, and that additional payments may be required if the assigned benefits are insufficient to pay for received services.

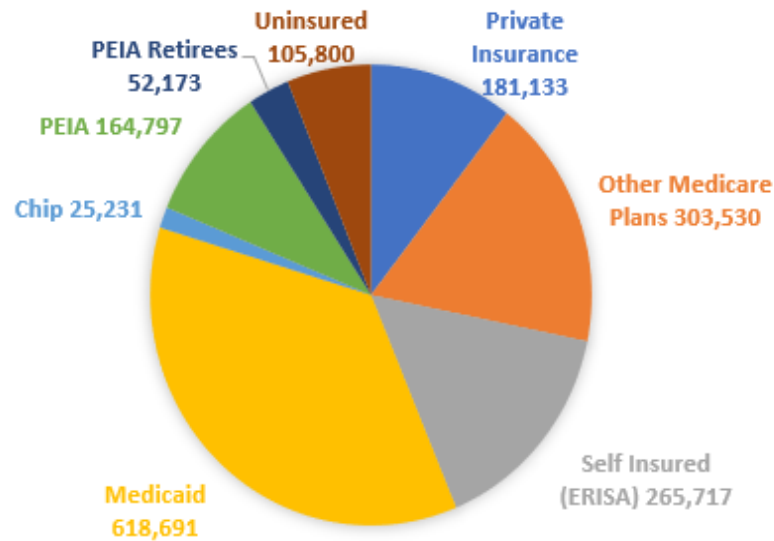
House Bill 4543 – Relating to insurance coverage for diabetics (Effective March 7, 2020)

This bill requires insurance coverage for prescription insulin drugs used to treat diabetes. The coverage must be in place with respect to an insurance policy, plan or contract that is issued or renewed on or after July 1, 2020. The bill mandates health insurers to cover at least one type of insulin in certain categories. The cost sharing payment, which is the total amount a covered person is required to pay at the point of sale in order to receive a prescription drug, for a 30-day supply of a covered prescription insulin drug may not exceed \$100 irrespective of the quantity or type of prescription insulin used to fill the covered person's prescription needs. The legislation further requires health insurers to provide coverage for the following diabetes-related equipment and supplies: blood glucose monitors, monitor supplies, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar, and orthotics. Coverage must also be provided for diabetes self-management education to ensure that persons are aware of proper self-management and treatment of their diabetes, including information on proper diets.



VIII. WV PUBLIC & PRIVATE HEALTH INSURANCE MARKET

2022 Covered Lives



2022 Population in West Virginia 1,775,156 (Estimate as of July 1, 2022)

(Numbers are from the references in section IX).



IX. REFERENCES

Population

<https://www.census.gov/quickfacts/fact/table/WV/PST045221#PST045221>

Medicare Enrollment

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html>

PEIA

Information provided by PEIA.

Uninsured

<https://www.kff.org/uninsured/state-indicator/distribution-uninsured-nonelderly-age/?dataView=1¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

Self-Insured

https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2021/ic21_iaa_f.pdf

WV CHIP

Information provided by CHIP.

Medicaid

<https://dhhr.wv.gov/bms/Members/Managed%20Care/Documents/Reports/Managed%20Care%20Monthly%20Enrollment%20report%20December%202022.pdf>

Health Insurance Enrollment

<https://www.cms.gov/newsroom/fact-sheets/federal-health-insurance-exchange-2019-open-enrollment>

X. TABLES OF HEALTH PRODUCTS 2016 – 2022

Summary of Tables 1 - 11

Comprehensive Health Insurance

- Table 1 - Individual Comprehensive
- Table 2 - Small Group (1-49 employees)
- Table 3 - Large Group (50 and more employees)

Medicare

- Table 4 - Medicare Supplement

Dental Only

- Table 5 - Dental Plans

Vision Only

- Table 6 - Vision Plans

Long-Term Care Insurance

- Table 7 - Individual Long-Term Care

Disability Income

- Table 8 – Short-Term and Long-Term Disability Income

The information on the “Tables of Health Products” is from the insurance companies’ annual statement filings with the NAIC.

Comments and questions about this report should be directed to:

Health Policy Division
West Virginia Offices of the Insurance Commissioner
900 Pennsylvania Avenue
Charleston, WV 25305-0540
304-414-8480
OICHealthPolicy@wv.gov



XI. Consumer Points of Contact for Health Insurance Services

Affordable Care Act (ACA)

Phone: 1-800-318-2596 or 1-855-889-4325

Website: www.hhs.gov

West Virginia Offices of the Insurance Commissioner (WVOIC)

Consumer Services Phone: 1-888-879-9842 or 304-558-4965

Consumer Services Fax: 304-558-4965

Website: www.wvinsurance.gov/Consumer_Services

State Health Insurance Assistance Programs (SHIP)

WV SHIP Counselor Phone: 304-558-3317 or 1-877-987-4463

WV SHIP Fax: 304-558-0004

Website: www.wvship.org

Centers for Medicare & Medicaid Services (CMS)

Phone: 1-800-633-4227 or 1-800-MEDICARE

Website: www.cms.gov

Children's Health Insurance Program (CHIP)

Phone: 1-877-982-2447 or 1-877-WVA-CHIP

Website: chip.wv.gov

Public Employees Insurance Agency (PEIA)

Phone: 1-888-680-7342

Website: peia.wv.gov

