WEST VIRGINIA INSURANCE BULLETIN
No. 23-02A

Insurance Bulletins are issued when the Commissioner renders formal opinions, guidance or expectations on matters or issues, explains how new statutes or rules will be implemented or applied, or advises of interpretation or application of existing statutes or rules.

► Amended Summary of 2023 Legislation ◄

This Insurance Bulletin summarizes legislation enacted during the 2023 Regular Session of the West Virginia Legislature that is significant to the Offices of the Insurance Commissioner. It does not include all legislation that may affect the insurance industry or consumers and is only intended to highlight the major points in the more important regulatory bills. The explanations contained herein should not be construed as being indicative of the Insurance Commissioner's views on, support of, or interpretation of, the legislation. The bills are available on the Legislature's website at www.wvlegislature.gov.

Senate Bill 146 – Relating to Peer-To-Peer Care Sharing Program (Effective June 8, 2023)

This bill amends the existing regulation of peer-to-peer car sharing programs in West Virginia by reducing the motor vehicle liability insurance limits for such programs from $750,000 to the state minimum financial responsibility limits set forth in W. Va. Code §17D-4-2 (currently $25,000 due to bodily injury to or death of one person in any one accident; $50,000 due to bodily injury to or death of two or more persons in any one accident; and $25,000 due to injury to or destruction of property of others in any one accident). The legislation further provides that if a claim occurs during the car sharing period in another state with minimum financial responsibility limits higher than required by W.Va. Code §17D-4-2, the coverage required under the law must satisfy the minimum financial responsibility limits of such other state. Finally, the legislation establishes requirements for when an insurer, insurers, or peer-to-peer car sharing program shall assume primary liability for a claim.

Senate Bill 267 – Relating to Prior Authorizations of Medical Services and Medications (Effective June 6, 2023)

This legislation modifies the requirements to be followed by the Public Employees Insurance Agency (PEIA) and private commercial health insurers regarding prior authorizations of medical services or medications. The bill further implements prior authorization requirements concerning health care coverage provided by the Bureau of Medical Services (Medicaid). (The entities subject to the prior authorization requirements - PEIA, Medicaid and commercial health insurers - are herein referred to as a "Subject Entity.")

The bill requires prior authorizations and related communications to be submitted via an electronic portal. Pursuant to the legislation, a Subject Entity must render a decision with respect to a completed prior authorization request within five business days. If the prior authorization request is incomplete and the health care provider submits the necessary information within three business days causing the prior authorization request to be deemed complete, a Subject Entity must render a decision within two business days after receipt of the additional information. With respect to appeals of a rejected prior authorization request, the timeframe of the appeal process must take no longer

than five business days from the date of any peer-to-peer consultation; however, a decision regarding a prior authorization appeal shall take no longer than ten business days from the date of the appeal submission.

In the event a health care provider has performed an average of thirty procedures per year and in a six-month time period during that year has received a 90% final prior approval rating, a Subject Entity may not require the practitioner to submit a prior authorization for at least the next six months or longer if the Subject Entity allows. This exemption is subject to internal auditing, at any time, by the Subject Entity and may be rescinded if it is determined that the health care provider is not performing services or procedures in conformity with the Subject Entity's benefit plan or the Subject Entity identifies substantial variances in historical utilization or other anomalies based upon the results of the Subject Entity's internal audit. The Subject Entity must provide a health care provider with a letter detailing the rationale for revocation of his or her exemption. Nothing with respect to the exemption provisions may be interpreted to prohibit a Subject Entity from requiring a prior authorization for an experimental treatment, non-covered benefit or any out-of-network service or procedure.

With respect to PEIA and commercial health insurers, the bill mandates that the Insurance Commissioner request data on a quarterly basis, or more often as needed, to oversee compliance with the prior authorization provisions. The data must include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each health care provider granted an exemption and the name of each health care provider whose exemption was revoked and the reason for revocation. The Insurance Commissioner may assess a civil penalty against PEIA or a commercial health insurer for a violation of a prior authorization requirement.

Senate Bill 345 – Relating to the Adoption of Rules (Effective March 10, 2023)

This bill authorizes the following legislative rules of the Insurance Commissioner:

114 CSR 11B – Suitability in Annuity Transactions

This rule was updated to require insurance producers (agents) to act in the best interests of consumers when making a recommendation of an annuity and to require insurers to establish and maintain a system to supervise recommendations so that the insurance needs and financial objectives of consumers at the time of the transaction are effectively addressed. This rule is based on the National Association of Insurance Commissioners' Suitability in Annuity Transactions Model Regulation (Model 275), as amended in the 1st quarter of 2020.

114 CSR 99 – Pharmacy Auditing Entities and Pharmacy Benefit Managers

This rule was amended to make the current rule comply with the changes to the Pharmacy Audit and Integrity Act, which was amended pursuant to House Bill 4112 (2022). The revisions to the rule include adding and removing definitions in the rule to track the code, adding the additional pharmacy accreditation prohibitions to the rule, adding the 30 days' notice provision for contract amendments and adding provisions to implement the process to address "specialty drug" complaints in conjunction with the Board of Pharmacy.

114 CSR 103 – Bail Bondsmen in Criminal Cases

This rule was amended to remove a state residency requirement for licensure. During consideration of the rule by the Legislative Rule-Making Review Committee, the Committee modified the rule to revise the definitions of "professional bondsman," "approved securities" and "surety

bondsman." The Offices of the Insurance Commissioner subsequently amended its proposed legislative rule to conform to the Committee's revisions.

Senate Bill 577 – Relating to Cost Sharing for the Treatment of Diabetes (Effective January 1, 2024)

This bill, which applies to health insurance provided by the Public Employees Insurance Agency and commercial health insurance companies, concerns cost sharing with respect to health care expenses relating to the treatment of diabetes. Cost sharing means any copayment, coinsurance or deductible required by or on behalf of an insured to receive a specific health care item or service covered by a health plan. The legislation provides that cost sharing for a 30-day supply of a covered prescription insulin drug may not exceed $35 in aggregate, including situations where the covered person is prescribed more than one insulin drug, per 30-day supply, regardless of the amount or type of insulin needed to fill such covered person's prescription. The bill further provides that cost sharing for a 30-day supply of a covered device may not exceed $100 in aggregate, including situations where the covered person is prescribed more than one device, per 30-day supply. Each cost-share maximum is required to be covered regardless of the person's deductible, copayment, coinsurance or any other cost-sharing requirement.

Senate Bill 594 – Relating to Cost Sharing for High Deductible Plans (Effective March 3, 2023)

This legislation amends West Virginia's "co-pay accumulator law" and concerns fairness in cost sharing calculations for certain health savings account-qualified high deductible health plans. This legislation provides that if, under federal law, application of the existing cost sharing requirement would result in a health savings account's ineligibility under Section 223 of the Internal Revenue Code, the existing cost sharing requirement will apply only for health savings account-qualified high deductible health plans after the enrollee has satisfied the minimum deductible required under Section 223 of the Internal Revenue Code. However, the bill further provides that, with respect to health savings account-qualified high deductible health plans and items or services that are preventive care, the cost sharing requirement will apply pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

Senate Bill 661 - Clarifying Preferential Recall Rights for Employees Sustaining Compensable Injury (Effective June 9, 2023)

This legislation amends W.Va. Code §23-5A-1 that currently provides that it is a discriminatory practice for an employer to fail to reinstate an employee who has sustained a compensable workers' compensation injury to the employee's former position of employment by specifying that the employee's demand to return to work must be made in writing and transmitted by the United States Postal Service, return receipt requested, to the employer's principal office for such reinstatement, and further specifies that the employee's position in which the employee sustained the compensable injury must still be available. Preferential recall rights are generally applicable for one year. However, this legislation creates a new subsection (c) regarding preferential recall when the employee is employed by a contractor as defined by W. Va. Code §30-42-3(d) and provides that preferential recall in that circumstance shall be no greater than 120 days from the date the employee is released by a duly licensed physician to return to his or her regular employment. The cited code section defines "contractor" as a person who in any capacity for compensation, other than as an employee of another, undertakes, offers to undertake, purports to have the capacity to undertake, or submits a bid to construct, alter, repair, add to, subtract from, improve, move, wreck, or demolish any building, highway, road, railroad, structure, or excavation associated with a project, development, or improvement, or to do any part thereof, including the erection of scaffolding or other structures or works in connection therewith, where the cost of the undertaking is $5,000 or more for residential work or $25,000 or more for commercial work. If the employee is employed by a contractor, as defined, it is the employee's obligation to continually seek the possibility of employment during the employee's preferential recall period and the employee's right to preferential recall terminates once the employer offers the employee his or her former position or a comparable position.

House Bill 2029 – Relating to the Repeal of the All-Payer Claims Database Act (Effective February 1, 2023)

This bill repeals W. Va. Code §33-4A-1 *et seq.* concerning an all-payer claims database. The repealed article required health care payers to submit health insurance claim data to the Secretary of the West Virginia Department of Health and Human Resources, with the Insurance Commissioner enforcing the requirement concerning commercial health insurers.

House Bill 2436 – Relating to the Implementation of an Acuity-Based Patient Classification System (Effective June 9, 2023)

This legislation requires medical facilities in this state to develop, by July 1, 2024, an acuity-based patient classification system to be used to establish a staffing plan for each unit of the facility. An acuity-based patient classification system is defined as a set of criteria based on scientific data that acts as a measurement instrument which predicts registered nursing care requirements for individual patients based on severity of patient illness, need for specialized equipment and technology, intensity of nursing interventions required and the complexity of clinical nursing judgment needed to design, implement and evaluate the patient's nursing care plan consistent with professional standards of care. The acuity-based system criteria must take into consideration the patient care services provided by registered nurses, licensed practical nurses and other health care personnel.

The bill also provides that commercial health insurers may not impose a copayment, coinsurance or office visit deductible amount charged to the insured for services rendered for each date of service by a licensed occupational therapist, licensed occupational therapist assistant, licensed speech-language pathologist, licensed speech-language pathologist assistant, licensed physical therapist or a licensed physical therapist assistant that is greater than the copayment, coinsurance or office visit deductible amount charged to the insured for the services of a primary care physician or an osteopathic physician. The insurance contract must clearly state the availability of occupational therapy, speech-language therapy, physical therapy coverage and all related limitations, conditions and exclusions.

House Bill 2540 – Relating to Travel Insurance (Effective June 9, 2023)

This bill creates a comprehensive legal framework within which travel insurance may be marketed and sold in this state through the establishment of regulatory obligations for those involved in the development and distribution of such insurance. The legislation is further intended to preserve the unique aspects of travel protection plans and protect consumers by encouraging fair and effective competition within the market. The bill defines terms; provides requirements for the licensure of a limited lines travel insurance producer; requires the producer to establish and maintain a register depicting each travel retailer that offers travel insurance on the producer's behalf; establishes a premium tax on travel insurance; requires the filing of forms and rates relating to travel insurance; establishes acceptable sales practices concerning travel insurance; provides requirements for a travel administrator, which is defined as someone who directly or indirectly underwrites, collect charges, collateral or premiums from, or adjusts or settles claims on, West Virginia residents in connection with travel insurance; allows for both individual and group travel insurance policies; grants the Insurance Commissioner enforcement powers; and permits rulemaking by the Insurance Commissioner.

House Bill 2621 – Relating to the Regulation of Bail Bondsmen (Effective June 8, 2023)

This legislation removes the exemption for bail bonding activities from the definition of "surety insurance" within the Insurance Code. The bill revises the definition of "approved securities" that a bail bondsman may pledge to issue bail bonds. Pursuant to the bill, permissive securities include cash, an irrevocable letter of credit, a bond issued by an insurance company licensed and in good standing in this state, a qualified power of attorney issued by an insurer pursuant to an insurance producer agreement or real estate located in this state. The legislation provides that a pledge of real estate as an approved security is not permitted after July 1, 2024; however, a bondsman who is licensed by the Insurance Commissioner as of July 1, 2024 and has pledged real estate as security

to conduct bail bonding business may continue to pledge real estate to operate as a licensed bondsman until his or her license is voluntarily surrendered or revoked by the Commissioner. The bill further requires the Insurance Commissioner to formulate testing requirements for all initial license applicants.

House Bill 3270 – Relating to Deliberate Intent Causes of Action (Effective June 8, 2023)

This bill amends the employer liability "deliberate intent" statute, W. Va. Code §23-4-2, by providing that the maximum amount recoverable as compensatory damages for noneconomic loss may not exceed the higher of two times the economic damages before offset or $500,000 for each person, regardless of the number of plaintiffs or the number of defendants or, in the case of wrongful death, regardless of the number of distributees. This statutory amendment is applicable to causes of action that accrue on or after July 1, 2023. The legislation further provides that with respect to deliberate intent causes of action involving occupational pneumoconiosis, the employee must prove that the employer fraudulently concealed or manipulated dust samples or air quality samples.

Please email any questions concerning this Insurance Bulletin to OICBulletins@wv.gov.

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Allan L. McVey
CPCU, ARM, AAI, AAM, AIS
Insurance Commissioner