



WEST VIRGINIA INSURANCE BULLETIN

No. 20 – 13

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.

► Summary of 2020 Legislation ◀

This Insurance Bulletin summarizes significant insurance and workers' compensation legislation enacted during the 2020 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 regulatory 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.wvlegislature.gov.

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 at a participating provider, and at no greater cost to the covered person than if the services were obtained from a participating provider.

Senate Bill 357 – Relating to the adoption of rules (Effective February 5, 2020)

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

114 CSR 24 - Medicare Supplement Insurance

The federal Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required changes to Medicare Supplement policies that cover the Part B deductibles for newly eligible Medicare beneficiaries on or after January 1, 2020. MACRA eliminated first dollar coverage regarding Medicare Supplement plans by discontinuing the sale of Plans C and F. A state that wishes to retain regulatory authority over Medicare Supplement products must implement any changes to federal laws impacting such products. The amendments made to Series 24 accomplishes that purpose.

114 CSR 40 - Credit for Reinsurance

During the 2018 regular session, the West Virginia Legislature enacted House Bill 4230. This legislation, which was based on a model law adopted by the National Association of Insurance Commissioners (NAIC), amended current requirements concerning credit for reinsurance and became effective January 1, 2019. The 2018 bill included a provision permitting the Insurance Commissioner to promulgate rules to implement the provisions of the law. The subject rule, which mirrors an emergency rule filed on January 1, 2019, is based on an NAIC model regulation. More specifically, the revised rule permits the Commissioner to allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that has been certified as a reinsurer in West Virginia at all times for which the credit is claimed. The permissible credit is based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the Commissioner.

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 689 – Relating to the Requiring Accountable Pharmaceutical Transparency, Oversight, and Reporting Act (Effective June 3, 2020)

This bill enacts the Requiring Accountable Pharmaceutical Transparency, Oversight, and Reporting Act, which imposes reporting requirements on drug manufacturers and health insurers. Health insurers must report to the State Auditor the following information no later than March 1 of each calendar year: (1) The names of the 25 most frequently prescribed prescription drugs across all plans; (2) The percent increase in annual net spending for prescription drugs across all plans; (3) The percent increase in premiums that were attributable to prescription drugs across all plans; (4) The percentage of specialty drugs with utilization management requirements across all plans; and (5) The premium reductions that were attributable to specialty drug utilization management.

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.

Senate Bill 849 – Relating to military service as factor in certain insurance coverage rates (Effective March 5, 2020)

This legislation prohibits an insurance company that offers fire, marine or casualty insurance from denying coverage, refusing to renew a policy, cancelling coverage or charging increased premiums for applicants or insureds solely as a result of a uniformed service member's performance of active military duty in the United

States armed forces or as a member of a reserve component of the United States armed forces, including National Guard service, because the uniformed service member failed to meet underwriting standards that require continuous coverage. If the failure to maintain continuous coverage existed prior to the applicant's or insured's entry into active duty status and was not related in any way to the applicant's or insured's military service, then the prohibition does not apply.

House Bill 4003 – Relating to telehealth insurance requirements (Effective June 5, 2020)

This bill requires health insurers, after July 1, 2020, to cover telehealth services if the same services are covered through face-to-face consultation by the policy, contract or plan. Telehealth services is defined by the legislation as “the use of synchronous or asynchronous telecommunications technology by a health care practitioner to provide health care services.” Reimbursements for telehealth services should be negotiated between the provider and the health insurer. A health insurer may not impose any annual or lifetime dollar maximum on coverage for telehealth services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy. Similarly, a health insurer may not impose upon a covered person any copayment, coinsurance or deductible amount for telehealth services that is not equally imposed upon all services covered under the policy, contract or plan. The bill further permits the originating site of the telehealth services to charge the health insurer a site fee.

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 in order 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 4146 – Relating to credit for reinsurance (Effective June 2, 2020)

This bill incorporates the relevant provisions of the “Bilateral Agreement Between the United States of

America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement), which was signed on September 22, 2017. The Covered Agreement eliminates reinsurance collateral requirements for European Union (EU) reinsurers that maintain a minimum amount of own funds equivalent to \$250 million and a certain solvency capital requirement. Conversely, U.S. reinsurers that maintain capital and surplus equivalent to 226 million euros with a risk-based capital of 300% of authorized control level would not be required to maintain a local presence in order to do business in the EU or post collateral in any EU jurisdiction. The bill is based on a model law adopted in 2019 by the National Association of Insurance Commissioners.

House Bill 4149 – Relating to service contracts and warranties (Effective May 27, 2020)

This legislation pertains to service contracts and warranties, which are exempted from regulation as insurance products in West Virginia. The bill clarifies or expands upon the types of products that are included within the statutory definitions of “service contract” and “warranty.”

House Bill 4198 – Relating to insurance coverage for contraceptive drugs (Effective June 5, 2020)

This bill requires a health benefit plan that is issued on or after January 1, 2021, and provides for coverage for contraceptive drugs, to provide coverage for a 12-month refill of contraceptive drugs obtained at one time by the insured after the insured has completed the initial supply of the drugs, unless the insured requests a smaller supply or the prescribing provider instructs that the insured must receive a smaller supply.

House Bill 4353 – Relating to a rational nexus requirement between prior criminal conduct and initial licensure decision making (Effective May 19, 2020)

This bill removes barriers to employment for individuals with criminal records who seek licensure or certification in an occupation governed by state laws, with certain exceptions. With respect to the portion of the bill that affects the Offices of the Insurance Commissioner, the legislation provides that the Commissioner may not disqualify a person seeking a license as a viatical settlement provider or viatical settlement broker due to a prior criminal conviction unless the conviction is for a crime which bears a rational nexus to the activity requiring licensure. The bill further provides that if a prior criminal conviction disqualifies the person from licensure, the Commissioner must nevertheless permit the person to apply for a license if: (1) A period of five years has elapsed from the date of conviction or the date of release from incarceration, whichever is later; (2) The individual has not been convicted of any other crime during the period of time following the disqualifying offense; and (3) The conviction was not for an offense of a violent or sexual nature. If the conviction involved an offense of a violent or sexual nature, the Commissioner may subject an individual to a longer period of disqualification from licensure. The bill also permits an individual to petition the Commissioner for a determination of whether the individual’s criminal record will disqualify the individual from obtaining a license without having to submit an application.

House Bill 4359 – Relating to filing fees (Effective July 1, 2020)

This legislation sets a flat filing fee with respect to insurance forms, rules and rates. The bill permits the Insurance Commissioner to charge \$100 as a flat fee regardless of whether an insurer makes a single filing or multiple filings.

House Bill 4361 – Relating to the Insurance Fraud Prevention Act (Effective June 5, 2020)

This bill updates the provisions of the Insurance Fraud Prevention Act, W. Va. Code §33-41-1 *et seq.* The legislation defines “fraudulent insurance act” and permits the Insurance Commissioner to accept proceeds of court ordered forfeiture proceedings involving such acts for the purpose of effectuating the Act’s provisions. The bill also requires a person engaged in the business of insurance to furnish and disclose to the Commissioner any information concerning a fraudulent insurance act or a suspected fraudulent insurance act. Moreover, the bill provides that insurance companies must have antifraud initiatives reasonably calculated to

detect, prosecute and prevent fraudulent insurance acts. The bill further allows the Insurance Fraud Unit within the Offices of the Insurance Commissioner to administer oaths and affirmations, execute search warrants and arrest warrants for criminal violations of the insurance laws of West Virginia or related criminal laws, and make arrests upon probable cause without a warrant regarding persons found in the act of violating or attempting to violate an insurance law or related criminal law. The arrest powers conveyed by the bill only pertain to employees of the Fraud Unit who the Commissioner designates and who are actively certified as law-enforcement officers under W. Va. Code §30-29-5.

House Bill 4466 – Relating to the Certificates of Insurance Act (Effective July 1, 2020)

This legislation enacts the Certificates of Insurance Act. The bill gives the Insurance Commissioner regulatory authority regarding the issuance of a certificate of insurance, which is defined in the legislation as “a document or instrument, regardless of how titled or described, that is prepared or issued by an insurer or insurance producer as evidence or confirmation of the existence of property or casualty insurance coverage.” The Commissioner may prohibit the use of a certificate of insurance form if the form is unfair, misleading, deceptive, or violates public policy, any law or insurance rule. The provisions of the bill apply to all certificates of insurance provided in connection with a property or casualty insurance policy that is issued or renewed on or after July 1, 2020. A person who violates a provision of the Act may, after notice and hearing, be fined by the Commissioner in an amount not to exceed \$1,000 per violation.

House Bill 4477 – Relating to the West Virginia Mutual to Mutual Insurance Holding Company Act (Effective February 28, 2020)

This bill enacts the West Virginia Mutual to Mutual Insurance Holding Company Act. The legislation prescribes a method whereby a mutual insurance company may reorganize its business and create a multi-level insurance holding company system. Two new entities would be created in a “mutual to mutual” reorganization: (1) A Mutual Insurance Holding Company, a non-stock corporate entity, which is the holding company system parent; and (2) An Intermediate Stock Holding Company, which is a subsidiary of the Mutual Insurance Holding Company. Pursuant to the bill’s provisions, a mutual insurer (Mutual) may be converted into a stock insurance company, which is controlled by its new shareholder, the Intermediate Stock Holding Company. At all times, at least 51% or more of the ownership rights of the Stock Holding Company must be held by the Mutual Insurance Holding Company. Policyholder rights in the Mutual are converted into membership rights in the larger, and more diversified, Mutual Insurance Holding Company. Policyholder membership interests in the Mutual are then extinguished. A policyholder’s contractual rights do not change as the converted stock company remains responsible for the payment of claims.

The reorganization plan must be approved by the Mutual’s policyholders. The Mutual’s board of directors is required to file the reorganization plan with the Insurance Commissioner within 90 days after adoption by the Mutual’s policyholders. The Commissioner must approve or reject the reorganization plan within 60 days after the approval of the reorganization plan by the Mutual’s policyholders or the completion of public hearings, whichever is later. If the Commissioner rejects the reorganization plan, the Commissioner’s notice must detail the reasons for the rejection.

House Bill 4502 – Relating to insurance adjusters (Effective June 4, 2020)

This legislation updates the requirements for insurance adjusters to become licensed, and maintain licensure, in West Virginia. The bill allows for three types of adjuster licenses in West Virginia - company adjuster, independent adjuster and public adjuster. The bill further requires that a company or independent adjuster be licensed under one or more of the following lines of authority: (1) property and casualty; (2) workers’ compensation; and (3) crop. A public adjuster may only qualify for a license designating a property and casualty line of authority. The bill also provides for exemptions to licensure; sets forth the criteria regarding temporary licensure for emergency company or independent adjusters; makes revisions concerning the qualifications for a resident adjuster license; authorizes the Insurance Commissioner to require an applicant

for a resident adjuster license to undergo a criminal history check; sets annual fees for each adjuster license type; defines what constitutes a violation of the article; and requires adjusters to biennially complete at least 24 hours of continuing education courses. The bill's provisions become effective on July 1, 2021.

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.

Please e-mail any questions concerning this Insurance Bulletin to OICBulletins@wv.gov or call (304) 558-0401.

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