



WEST VIRGINIA INSURANCE BULLETIN No. 26-02

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 2026 Legislation ◀

This Insurance Bulletin summarizes legislation enacted during the 2026 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 556 – Relating to the Priority of Automobile Insurance Coverages (Effective June 9, 2026)

This bill provides that statutorily mandated automobile liability insurance coverage concerning a vehicle owned by a person, firm or corporation engaged in the business of selling, repairing or servicing motor vehicles is secondary to such coverage under an individual's motor vehicle liability insurance policy.

Senate Bill 645 – Relating to Ground Emergency Medical Services Billing Practices (Effective June 11, 2026)

This legislation requires commercial health insurance plans issued by an insurer on or after January 1, 2027 to pay out-of-network ambulance companies for covered ambulance services at a rate of 200% of the current published rate for ambulance services as established by the Centers for Medicare and Medicaid Services for the same ambulance services provided in the same geographic area, or according to the non-participating ambulance company's billed charges, whichever is less. The payment rate does not apply to air ambulance services as defined in W. Va. Code §16-4C-3(a). The payment shall be considered payment in full for the ambulance services except for any copayment, coinsurance, deductible and other cost-sharing amounts that the insurer requires the covered enrollee to pay. The out-of-network ambulance company may not bill the covered individual for any additional amount for the ambulance services provided. Upon receipt of a clean claim, the insurer must remit payment directly to the ambulance company within 30 days and shall not send the payment to the covered individual. The claim is required to be paid within the designated timeframe unless certain enumerated conditions exist. If an insurer denies the claim, the insurer is required to provide written notice that the insurer is declining to pay all or part of the claim and set forth the specific reason or reasons for declining to pay the claim in full or state that additional information is needed to determine whether all or part of the claim is payable and specifically describe the additional information that is needed.

House Bill 4089 – Relating to the Preservation of Hair During Chemotherapy (Effective June 8, 2026)

This bill provides that a health insurer who underwrites a policy, plan or contract that is issued or renewed on or after January 1, 2027 must provide coverage for scalp cooling systems used in connection with cancer chemotherapy treatment as defined by the Centers for Medicare and Medicaid Services. “Scalp cooling system” is defined in the bill as any device used to cool the human scalp to prevent or reduce hair loss during cancer chemotherapy treatment, provided that such device is designed and intended for repeated use and is primarily and customarily used to serve a medical purpose. The coverage required by the legislation may be subject to annual deductibles and coinsurance, including copayments, as may be deemed appropriate by the Insurance Commissioner and as are consistent with those established for other benefits within a given policy.

House Bill 4245 – Relating to the Authorization of Rules (Effective March 14, 2026)

This bill authorized the repeal of the following three outdated rules of the Insurance Commissioner: 114 CSR 7 – Premium Financing of Life Insurance for College Students; 114 CSR 9 – Mass Marketing of Property and Liability Insurance; and 114 CSR 10 – Advertisement of Accident and Sickness Insurance.

The legislation approved the following four Insurance Commissioner rules to extend their sunset dates until August 1, 2036: 114 CSR 02A – Fingerprinting Requirements for Applicants for Insurance Producer License and Insurance Adjuster License; 114 CSR 25 – Insurance Adjusters; 114 CSR 40 – Credit for Reinsurance; and 114 CSR 64 – Mental Health Parity.

The bill also authorized the proposed revisions to 114 CSR 35 (Insurance Holding Company Systems). During the 2025 Regular Session, the West Virginia Legislature adopted the National Association of Insurance Commissioners’ Model Act #440 through the enactment of Senate Bill 800. One of the primary purposes of Senate Bill 800 was to establish group capital calculation (GCC) filing requirements for insurance companies that are a part of an insurance holding company system. The GCC provides U.S. solvency regulators with an additional analytical tool for conducting group-wide supervision and assists regulators in understanding the financial condition of non-insurance entities. The GCC is intended to provide vital financial information about the insurance group; quantifies risk across the insurance group; supports transparency into how capital is allocated; and aids in understanding whether and to what degree insurance companies are supporting the operations of non-insurance entities. The amendments to 114 CSR 35, which are based on NAIC Model Regulation #450, include provisions allowing the Insurance Commissioner to grant exemptions to GCC reporting for groups meeting certain standards. Moreover, the rule revisions allow the Insurance Commissioner to require an insurance holding company who has been granted an exemption with respect to GCC reporting to file an annual GCC at any time if certain criteria are met.

House Bill 4869 – Relating to Guaranteed Issue Rights Regarding Medicare Supplement Policies (Effective June 11, 2026)

This legislation provides guaranteed issue rights for Medicare Supplement (Medigap) policies in West Virginia. The guaranteed issue right set forth in the bill is available if the individual’s existing Medigap policy has been continuously in force for at least 24 months as of the effective date of the replacement policy. Each replacement policy is subject to the same 24-month continuous coverage requirement before it may be replaced again. Subject to the 24-month continuous coverage requirement, an individual who is enrolled in a Medigap policy has a guaranteed issue right once per calendar year to replace that policy. The guaranteed issue application period begins on the first day of the month of the individual’s birthday and ends 60 days thereafter. The replacement Medigap policy must be issued by the same insurer that issued the existing policy or by an affiliated insurer and must provide the same or less standardized Medigap benefits as the policy being replaced. However, if neither the issuing insurer nor any affiliated insurer of the individual’s existing policy has accepted applications for a Medigap policy providing the same or less standardized benefits for a period of at least 12 months, the individual may purchase a

Medigap policy providing the same or less standardized benefits from any insurer authorized to issue Medigap policies in this state. With respect to the replacement Medigap policy as provided in the bill, the insurer may not deny issuance, impose medical underwriting or impose a pre-existing condition exclusion or waiting period. The legislation also provides that an individual has a guaranteed issue right to purchase a Medigap policy who is 65 years of age or older on the date the individual's Medicaid eligibility ends, is entitled to Medicare and loses eligibility for medical assistance under Medicaid. For those individuals, he or she may purchase any Medigap policy that is actively offered for sale to new enrollees at the time of application by any insurer authorized to issue Medigap policies in West Virginia. The bill further requires the OIC to submit an annual report to the Legislature regarding Medigap policy premium trends in this state. The report is to be informational in nature and may not be construed to authorize premium regulation, rate setting or modification of rating methodologies. The requirements of the bill are to apply to all applicable insurance policies issued or renewed on and after June 1, 2026, or at any time thereafter when any term of the policy is changed or any premium adjustment is made.

House Bill 5430 – Relating to Pharmaceutical Benefits (Effective March 13, 2026)

This bill amends the Pharmacy Audit Integrity Act, W. Va. Code §33-51-1 *et seq.* The legislation provides that a pharmacy benefits manager (PBM) may not utilize, participate in or own any part of a group purchasing organization (GPO) for purposes of avoiding the requirements of the Act. A GPO is defined as an entity that purchases, arranges for or negotiates the purchase of covered drugs, devices, biologicals or medical supplies for a group of individuals or entities, but not solely for use by the entity itself. The bill also states that a PBM may not charge a health care payor or health benefit plan an amount greater than the national average drug acquisition cost (NADAC), if available, for prescription drugs. If the NADAC is not available, a PBM may not charge a health care payor or health benefit plan an amount greater than the amount paid to the pharmacy. The legislation requires the Insurance Commissioner to conduct a study of the cost to dispense outpatient prescription drugs in the state by soliciting data and relevant information from licensed pharmacies and analyzing similar studies conducted in surrounding states within the previous two years. The study must be completed and submitted to the Legislative Oversight Commission on Health and Human Resources Accountability and the Joint Standing Committee on Insurance and PEIA by December 1, 2026, and biennially thereafter.

House Bill 5459 – Relating to Tax on Health Maintenance Organizations (Effective June 9, 2026)

This legislation creates a new tax structure with respect to health maintenance organizations (HMOs) operating under a certificate of authority in West Virginia. As set forth in the bill, HMOs would be subject to a 2½% tax based on gross premiums written in this state during each calendar quarter. The new tax is applicable to all HMOs operating in this state, irrespective of their share of Medicaid, Medicare, commercial or non-Medicaid membership. The new tax would not apply to Medicare Advantage plans, a health plan issued by the West Virginia Public Employees Insurance Agency or a plan issued pursuant to the Federal Employees Health Benefits Act of 1959. "Gross premiums" is defined in the legislation as the total premiums, capitation payments or other consideration received by the HMO for providing or arranging health care services to enrollees in this state. Subject to federal approval that the new tax structure is a permissible health care-related tax in accordance with 42 C.F.R. §433.68 and is therefore eligible for federal financial participation, the tax structure set forth in the bill will become effective July 1, 2027. Until July 1, 2027, the tax provisions in effect prior to the bill's enactment remain in full force and effect.

House Bill 5462 – Relating to Insurance Coverage for Mine Subsidence (Effective June 12, 2026)

This legislation provides that any amounts paid to a mine subsidence insurance policyholder for an incurred covered loss pursuant to W. Va. Code §33-30-1 *et seq.*, whether received before or after submission of the loss to the insurer, must first be applied to property damages. If a source other than the mine subsidence insurance fund provides payment to an insured for a loss insured by the mine subsidence insurance program, the bill requires that the fund is only liable up to the statutory limit of reinsurance (\$200,000) for the portion of the loss not paid by the

other source. The legislation further states that the Legislature finds that insurers providing mine subsidence insurance pursuant to the provisions of W. Va. Code §33-30-1 *et seq.* facilitates the availability of such coverage through and on behalf of the Board of Risk and Insurance Management (BRIM). Accordingly, the bill provides that a policyholder may not bring a cause of action or any other action against the insurer for claims which have been reported to BRIM arising out of or relating to Article 30, Chapter 33 of the West Virginia Code.

House Bill 5515 – Relating to Updating Workers’ Compensation Statutes (Effective June 12, 2026)

This bill revised outdated and/or unnecessary provisions within Chapter 23 of the West Virginia Code, which pertains to workers’ compensation insurance. The legislation also repealed certain sections within Chapter 23 that are obsolete.

House Bill 5527 – Relating to Wellness Reimbursement Programs (Effective June 12, 2026)

This legislation requires the Insurance Commissioner to license and regulate wellness reimbursement programs. A “wellness reimbursement program” is defined in the bill as a plan offered to an employer or employee that provides reimbursement or other wellness-related benefits intended to promote health or wellness. Such programs include employer-sponsored wellness reimbursement arrangements or other wellness benefit structures offered through insurance or similar benefit models that have issued a contract to provide services and pay claims pertaining to reimbursements of qualified medical expenses relating to federal law and are intended, created, marketed and sold as an ancillary product to an individual or group health insurance coverage or self-insured group health plan.

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