STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

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Insurance Commissioner

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WEST VIRGINIA INFORMATIONAL LETTER

NO. 203

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 2019 Legislation

This Informational Letter summarizes significant insurance and workers' compensation legislation enacted during the 2019 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.wvlegislature.gov.

Senate Bill 30 – Eliminating tax on annuity considerations collected by life insurer (Effective June 7, 2019)

The legislation amends W.Va. Code § 33-5-15 to repeal the premium tax on life insurance annuity products, effective January 1, 2021. Presently, the tax imposed is 1%.

Senate Bill 240 – Repealing certain legislative rules no longer authorized or obsolete (Effective February 11, 2019)

The bill repeals certain legislative rules that are no longer authorized or are considered obsolete. The legislation repeals the following Insurance Commissioner rules:

114 CSR 29 - Health Insurance Benefits for Temporomandibular and Craniomandibular Disorders

114 CSR 31 - Guaranteed Loss Ratios as Applied to Individual Sickness and Accident Insurance Policies

114 CSR 58 - External Review of Coverage Denials

114 CSR 73 - Small Employer Eligibility Requirements

Senate Bill 310 – Establishing certain requirements for dental insurance (Effective July 1, 2019)

The bill prohibits insurers from requiring dentists to provide a discount on noncovered services, prohibits dentists from charging covered persons more for noncovered services than their customary or usual rate for the services; and mandates that insurers may not provide for a nominal reimbursement for a dental service or material to claim that the service or material is covered. The new provisions will apply to dental plans, contracts and participating provider agreements which take effect or are renewed on or after July 1, 2019.

Senate Bill 340 – Repealing obsolete provisions of code relating to WV Physicians Mutual Insurance Company (Effective June 6, 2019)

The legislation repeals Article 20F, Chapter 33 of the West Virginia Code with respect to the formation and operation of the West Virginia Physicians' Mutual Insurance Company (the "Company"). The provisions being repealed were enacted in 2001 in response to a crisis relating to the cost and availability of medical malpractice insurance. The Company is now operating, and is being regulated by the Insurance Commissioner, in the same manner as other casualty insurance carriers issuing similar policies in the state.

Senate Bill 485 – Clarifying notification requirements for property insurance purposes (Effective March 7, 2019)

The bill provides that when a homeowners insurer intends to transfer a policyholder between companies within the same insurance group, the insurer must provide notice to the policyholder of such intention and include an explanation of the reason(s) for the transfer. The legislation further states that when an insurer seeks to renew a property insurance policy with a new policy which includes changes made by the insurer resulting in the removal of coverage, diminution in the scope or reduction in coverage, change in deductible or addition of an exclusion, the insurer must provide such notice to the policyholder of such intention and include an explanation of the changes expected to be made by the insurer. This requirement does not apply to any change, reduction or elimination of coverage made at the request of the insured, any correction of typographical or scrivener's errors or the application of mandated legislative changes.

Senate Bill 489 – Relating to the Pharmacy Audit Integrity Act (Effective February 26, 2019)

The legislation requires pharmacy benefit managers (PBMs) to obtain a license from the Insurance Commissioner. An application for licensure must be submitted within six months after the Insurance Commissioner promulgates a legislative rule that addresses the required qualifications of PBMs and sets forth penalties and fines for violations of applicable law or rule provisions. The bill mandates certain information that the application must capture and provides that the license is valid for two years. The application for licensure, and subsequent renewal application, must be accompanied by evidence of financial responsibility of $1 Million.

The bill further requires a PBM to provide the Insurance Commissioner with a report describing the PBM's network. The network may not be comprised of only mail-order benefits, but must have a mix of mail-order benefits and physical stores in the state. Failure to provide a timely network report is grounds for suspension or revocation of a PBM's license.

The OIC may examine or audit a PBM's books and records to determine if the PBM is following applicable law. Any information or data acquired during an examination or audit of the PBM is deemed proprietary, confidential and exempt from disclosure under the Freedom of Information Act.

The bill further provides that a PBM which reimburses a 340B entity for drugs that are subject to an agreement under 42 U.S.C. § 256b shall not reimburse the 340B entity for pharmacy-dispensed drugs at a rate lower than that paid for the same drug to pharmacies similar in prescription volume that are not 340B entities. A PBM may not discriminate against a 340B entity in a manner that prevents or interferes with the patient's choice to receive such drugs from the 340B entity. A 340B entity is "an entity participating in the federal 340B drug discount program, as described in 42 U.S.C. § 256b, including its pharmacy or pharmacies, or any pharmacy or pharmacies, contracted with the participating entity to dispense drugs purchased through such program."

The legislation also defines when an auditing entity may seek a fee, charge-back, recoupment or other adjustment for a dispensed product or any portion of a dispensed product. Any such fee, charge-back, recoupment or other adjustment is limited to the actual financial harm associated with the dispensed product or the actual underpayment or overpayment.

Senate Bill 531 – Relating generally to workers' compensation claims (Effective June 4, 2019)

The bill amends W. Va. Code § 23-5-7 relating to the compromise and settlement of workers' compensation claims. The law currently provides that the claimant may negotiate a final settlement of any and all issues in a claim, provided that in the settlement of medical benefits for non-orthopedic occupational disease claims, the claimant must be represented by legal counsel. The subject bill amends W.Va. Code § 23-5-7 to provide that, for the purposes of that code section only, the term "non-orthopedic occupational disease" claim does not include an occupational hearing loss or hearing impairment claim.

Senate Bill 545 – Relating to HIV testing (Effective March 2, 2019)

The bill eliminates the specific HIV/AIDS testing protocols required to be used by insurers in connection with applications for life and health insurance policies, as set forth in 114 CSR 27. The effect of the amendment is that insurers must use an acceptable testing protocol to deny coverage or rate a substandard risk, including the use of FDA-licensed tests, but are not required to follow any specific testing protocol set forth by the Commissioner.

House Bill 2351 – Relating to regulating prior authorizations (Effective February 20, 2019)

The legislation requires the Public Employees Insurance Agency, managed care organizations and private commercial health insurers (collectively referred to herein as the "Subject Entities") to develop prior authorization forms by October 1, 2019. The forms must include (1) instructions for the submission of clinical documentation; (2) an electronic notification confirming receipt of the prior authorization request if the forms are submitted electronically; (3) a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else requiring a prior authorization; and (4) a notice to the patient if the Subject Entity requires a plan member to use step therapy protocols.

The Subject Entities must be prepared to accept electronic prior authorization requests, and respond to the requests through electronic means, by July 1, 2020. If the Subject Entity is currently accepting electronic prior authorization requests, it must implement the provisions of the bill by January 1, 2020. A response to an electronic prior authorization request must be provided seven days from receipt. A two-day response is mandated if the request is for medical care or other services for a condition in which a seven-day response could either seriously jeopardize the life, health, or safety of the patient or others, or subject the patient, in the opinion of a health care practitioner, to adverse health consequences without the requested care or treatment.

If a prior authorization request is incomplete, the Subject Entity shall identify all deficiencies and return the prior authorization to the health care practitioner within two business days from the date of the electronic receipt of the request. The health care practitioner must provide the additional information requested within three business days from the date the return request is received or the request is deemed denied and a new request must be submitted.

The Subject Entities must use national best practice guidelines to evaluate a prior authorization request. If a prior authorization request is rejected and the health care practitioner who submitted the request asks for an appeal by peer review, the peer review shall be with a health

care practitioner similar in specialty, education and background. However, the Subject Entity's medical director may ultimately decide the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. The timeframe regarding the appeal process must not take longer than thirty days.

If a health care practitioner has performed an average of thirty procedures per year and in a six-month time period has received a 100% prior approval rating, the bill provides that a Subject Entity shall not require the practitioner to submit a prior authorization for that procedure for the next six months. At the end of the six-month timeframe, the exemption must be reviewed prior to renewal. This exemption may be rescinded if the Subject Entity determines the health care practitioner is not performing the procedure in conformity with the insurance contract or plan.

The timeframes set forth in the bill are not applicable to prior authorization requests submitted through telephone, mail or fax.

House Bill 2474 – Relating to a reserving methodology for health insurance and annuity contracts (Effective June 7, 2019)

The bill amends West Virginia's "Standard Valuation Law," which authorizes a principle-based reserving methodology for life, annuity and health policies. West Virginia amended its Standard Valuation Law in 2014 to provide for a principle based reserving methodology for life, annuity and health policies. The 2019 revisions to West Virginia's "Standard Valuation Law," clarify that the principle based reserving methodology is to be applied to accident and health insurance contracts.

House Bill 2476 – Relating to the valuation of a motor vehicle involved in an insurance claim (Effective June 2, 2019)

The legislation updates W. Va. Code § 33-6-33 by striking the reference to the 5% excise tax and replacing it with language referring to the consumer sales tax in W. Va. Code § 11-15-3c(b). W. Va. Code § 33-6-33 currently provides that, upon the total loss of a motor vehicle, the insurer must include a payment equal to 5% of the cash settlement value as reimbursement to the claimant for the excise tax imposed by W. Va. Code § 17A-3-4. The excise tax on the purchase of a motor vehicle was abolished and replaced with a sales tax, currently 6%. This legislation does not increase any tax, but updates the code language to refer to the tax that is currently imposed.

House Bill 2479 – Corporate Governance Annual Disclosure Act (Effective June 7, 2019)

The bill requires insurers writing more than $500 Million or insurance groups writing more than $1 Billion in annual premium to maintain an internal audit function providing independent, objective and reasonable assurance to the audit committee and insurer management regarding the insurer's governance, risk management and internal controls. An "audit committee" is a committee or equivalent body established by the Board of Directors of an insurer or insurer group for the purpose of overseeing the accounting and financial reporting processes of the insurer or insurer group.

The legislation also requires an insurer or insurer group to provide confidential disclosures regarding its corporate governance practices to the lead state and/or domestic regulator annually by June 1. The annual disclosure will include the board or other entity responsible for overseeing the insurer or insurer group and the levels at which that oversight occurs. The insurer or group insurer will also be required to report, among other things, its processes for performance evaluation, compensation and corrective action to ensure effective senior management throughout the organization.

House Bill 2480 – Relating to the regulation of an internationally active insurance group (Effective June 6, 2019)

The bill revises the West Virginia Insurance Holding Company Systems Act. The amendments provide authority to a designated state to act as a group-wide supervisor for an internationally active insurance group ("IAIG"). For a holding company group to be considered an IAIG, it must meet various criteria, including premiums written in at least three countries, at least 10% of premiums written outside the United States, and total assets greater than $50 Billion or total premiums greater than $10 Billion. A group-wide supervisor may request group-level information from an IAIG, assess the enterprise risks affecting the group, compel the development and implementation of reasonable measures to recognize and mitigate enterprise risks, and communicate and share group-wide information with other regulators.

House Bill 2617 – Relating to the form for making offer of optional uninsured and underinsured coverage by insurers (Effective June 5, 2019)

This legislation provides that insurers are permitted to make the required offers of uninsured motor vehicle coverage and underinsured motor vehicle coverage via electronic means and allows for electronic signatures in conformity with the Uniform Electronic Transactions Act. Delivery by electronic means is not required and is only permitted if the policyholder has consented. The bill also requires an insurer, when offering to place an insured with an affiliate of the insurer, to make available a new uninsured and underinsured motorist coverage offer form.

House Bill 2647 – Self Storage Limited License Act (Effective June 5, 2019)

The legislation establishes a limited lines producer license for self-service storage providers. The bill permits the Commissioner to provide a limited lines license to an owner or operator of a self-service storage facility for the purpose of soliciting and selling self-service storage insurance. Such insurance is defined as "personal property insurance offered in connection with and incidental to the lease or rental of leased space at a self-service storage facility that provides coverage to occupants at the self-service storage facility where the insurance is transacted for the loss of or damage to personal property that occurs at that facility or when the property is in transit to or from that facility during the period of the rental agreement."

The subject license would apply to the owner's employees and authorized representatives. A licensee would not be subject to the agent pre-licensing education, examination or continuing education requirements provided in W. Va. Code § 33-12-1 *et seq*. However, the insurer issuing the self-service storage coverage must appoint a supervising entity to supervise the administration of the program that includes development of a training regimen for employees and authorized representatives. The bill requires the owner to provide certain disclosures to a prospective purchaser of the subject insurance, including that the insurance may present a duplication of insurance already provided by the prospective purchaser's homeowners or renters insurance and that the purchase of the insurance is not required in order to rent space from the owner. The owner must also summarize the material terms of the insurance coverage and inform the prospective purchaser that he or she may cancel the coverage at any time. Employees and authorized representatives may receive compensation for enrolling occupants for the coverage if the compensation for those activities is incidental to their overall compensation.

The Commissioner may impose a fine not to exceed $500 per violation or $5,000 in the aggregate, and impose other discretionary penalties, for violations of the bill's provisions by an owner or its employees or authorized representatives. A supervising entity may be subject to administrative actions provided by W. Va. Code § 33-12-24 if the Commissioner determines that the entity has not performed its required duties under the legislation.

House Bill 2690 – Relating to guaranty associations (Effective May 29, 2019)

The bill updates Chapter 33, Article 26A, West Virginia Life and Health Insurance Guaranty Association Act (the "Act"). The legislation removes the requirement that the Insurance Commissioner promulgate a rule establishing the form and content of a disclaimer that describes the general purposes and current limitations of the Act. Under the law's revision, the Commissioner simply needs to establish the form and content of the disclaimer. The disclaimer must be provided by life and health insurers to their insureds at the time of delivery of the policy or contract. The bill requires an insurer to retain evidence of delivery of the disclaimer to an insured for so long as the policy or contract remains in effect.

The bill further eliminates the mandate for the Insurance Commissioner to promulgate a rule creating a notice of non-coverage to be used by life and health insurers and removes the requirement that life and health insurers provide that notice of non-coverage to their insureds.

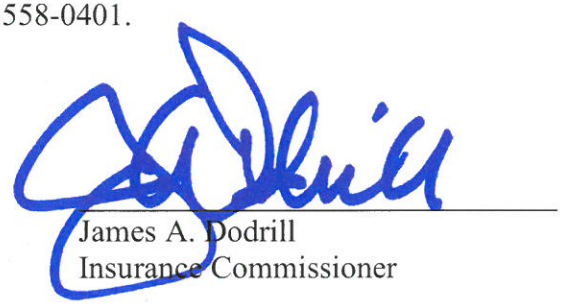
House Bill 2770 – Fairness in Cost-Sharing Calculation Act (Effective June 7, 2019)

The legislation creates the Fairness in Cost Sharing Calculation Act by establishing cost sharing calculations for health insurance plans and pharmacy benefits. The bill provides that when an insured's contribution to an applicable cost sharing requirement is calculated, the insurer and pharmacy benefits manager must include any cost sharing amounts paid by the insured or on behalf of the insured by another person. Cost sharing means any copayment, coinsurance or deductible required by or on behalf of an insured in order to receive a specific health care item or service covered by a health plan. The new provisions are effective for policies, contracts, plans, or agreements issued or renewed on or after January 1, 2020.

House Bill 2954 – Defining certain terms used in insurance (Effective June 5, 2019)

The bill amends the definition of "provider" in W. Va. Code §33-45-1(10) to include a person or other entity who desires to provide medical services in this state and holds a valid temporary license or permit issued pursuant to Chapter 30 of the West Virginia Code. The legislation further clarifies that an insurer is obligated to pay a medical provider for services rendered during the provider's credentialing period, and that an insurer may obtain a refund of overpayments should the provider fail to become credentialed.

Please e-mail any questions concerning this Informational Letter to OICInformationalLetters@wv.gov or call (304) 558-0401.



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