WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER
Medical Malpractice Insurance Review Standards Checklist

Medical Malpractice		
REVIEW REQUIREMENTS	**REFERENCE**	**COMMENTS**
FORMS		
Applications	**REFERENCE**	**COMMENTS**
Fee, filing	§33-6-34	The Filing Fee is $50.00 per Form filing and applies on a per company basis.
Submission, filing	WVIL (Informational Letter) 163	All filings **must** be submitted through SERFF (System for Electronic Rate and Form Filing). Filing fees **must** be remitted via EFT (Electronic Funds Transfer) through SERFF.
Filing Standards	**REFERENCE**	**COMMENTS**
Filing Requirement	§33-6-8(a) §33-6-8(e)(3)	Must be filed with and approved by the commissioner, or conform to applicable rules approved by the commissioner.
Time	§33-6-8(b)(1)	Filing must be made not less than sixty days in advance of delivery.
Approval	§33-6-8(b)(1)	After sixty days, a form is considered approved unless express disapproval has been received from the commissioner.
Suggested Lead Time for filings	§33-6-8(b)(1) §33-6-8(e)(3)	Should be filed at least sixty days prior to either the effective date requested or to the date that our final disposition needs to be known.
Disapproval Reasons for Disapproval	§33-6-8(c) §33-6-9	The commissioner may at any time disapprove or withdraw an approval for a form. The commissioner shall state the grounds for withdrawal or disapproval. Any form shall be disapproved under any of the following conditions: 1. The form is in violation of or does not comply with Chapter 33 of the West Virginia Code. 2. The form contains or references any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract. 3. The form has any title, heading, or other indication of its provisions which is misleading. 4. The purchase of such policy is being solicited by deceptive advertising. 5. The benefits provided therein are unreasonable in relation to the premium charged. 6. The coverages provided therein are not sufficiently broad to be in the public interest.

WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER
Medical Malpractice Insurance Review Standards Checklist

Contents	REFERENCE	COMMENTS
Basic Contents	§33-6-11	Must specify the names of the parties to the contract, the insurer's name, the subject of the insurance, the risks insured against, the time the insurance coverage becomes effective and the term during which such coverage continues, the premium, and the conditions pertaining to the insurance.
Additional Contents	§33-6-12	A policy may contain additional provisions if they are: 1. Consistent with Chapter 33. 2. Required to be inserted by the laws of the insurer's domicile. 3. Necessary, because of the manner in which the insurer is constituted or operated, in order to state the rights and obligations of the parties. 4. Desired by the insurer and not prohibited by law nor in conflict with any provisions required to be included therein.
Charter, Bylaws, Other Documents	§33-6-13	No policy shall contain any provision purporting to make any portion of the charter, bylaws, or other constituent document of the insurer a part of the contract unless such portion is set forth in the full policy.
Signature	§33-6-15	Every policy shall be executed in the name of and on behalf of the insurer by its officer, attorney-in-fact, employee, or representative duly authorized by the insurer.
Non-WV Laws	§33-6-14	No policy may contain any condition, stipulation or agreement requiring such policy to be construed according to the laws of any other state or country, except as necessary to meet the requirements of the motor vehicle financial responsibility laws or compulsory disability benefit laws of such other state or country.
Legal Action Against Insurer	§33-6-14	No policy may contain any condition, stipulation or agreement preventing the bringing of an action against the insurer for more than six months after the cause of action accrues or limiting the time within which an action may be brought to a period of less than two years from the time the cause of action accrues in connection with all insurances. Any such condition, stipulation or agreement shall be void, but this shall not affect the validity of the other provisions of the policy.
Payment of Loss Provisions	§114-14-6 (6.11)	Every insurer shall pay any amount finally agreed upon in settlement of all or part of any claim no later than 15 working days from the receipt of agreement by the insurer, or from the date of the performance by the claimant of any condition set by such agreement, whichever is later.
Arbitration and Appraisal Provisions	*WVIL* 119-B	Arbitration and appraisal provisions are not required but if they are included the language must be as favorable to the insured as that set forth in *WVIL* 119-B.

WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER
Medical Malpractice Insurance Review Standards Checklist

Cancellation & Nonrenewal	REFERENCE	COMMENTS
Notification	§33-20C-3	Written notice of **cancellation** must be forwarded to the insured by certified mail, return receipt requested, not more than 30 days after the reason for such cancellation arose or occurred or the insurer learned that it arose or occurred and not less than 30 days prior to the effective cancellation date. The insurer shall cite within the written notice of the action the allowable reason and shall state the specific circumstances giving rise to the cited reason. The notice shall further state that the insured has a right to request a hearing pursuant to §33-20C-5 within 30 days.
	§33-20C-4(a) §33-20C-4(b)	Written notice of **nonrenewal** must be forwarded to the insured by certified mail, return receipt requested, not less than ninety days prior to the expiration date of such policy.
Permissible Reasons	§33-20C-2	Cancellation may not be issued unless it is based on at least one of the following reasons: 1. The Insured fails to discharge any of their obligations to pay premiums or any installment thereof within a reasonable time of the due date. 2. The policy was obtained through material misrepresentation. 3. The insured violates any of the material terms and conditions of the policy. 4. The unavailability of reinsurance, upon sufficient proof thereof being supplied to the commissioner. Any purported cancellation of a malpractice policy attempted in contravention of these standards shall be void.
Tail Offer (Extended Reporting Period)	§33-20D-3, §114-30-4	Upon cancellation, nonrenewal or termination of any claims-made malpractice policy, the insurer must offer tail coverage, such offer shall be valid for 45 days. The tail insurance coverage offer may be accepted sooner, in writing, by the insured.
	§114-30-4, §114-30-5	Upon termination of any claims-made malpractice policy, the insurer must offer the opportunity to amortize the quarterly payment of premiums for tail insurance over a period of either 12, 24, or 36 months. The payments shall be amortized at a per annum rate of interest equal to 2 percentage points above the prime interest rate reported in the *Wall Street Journal* on the date when the insurer receives the insured's request to purchase tail insurance, or on the next publication date if not published on the date when the request is received. The quarterly payments must equal at least $750.00 each to necessitate this offer requirement.
	§114-30-6	The first quarterly payment shall be payable contemporaneously with the issuance of the tail insurance policy. Subsequent payments shall be due and payable quarterly thereafter.
	§33-20D-3	Each licensed malpractice insurer shall submit for approval, by the commissioner, a plan for determination of partial limits in the event of default on amortized payment.

Unfair Trade Practices	REFERENCE	COMMENTS
Unfair or Deceptive Practices	§33-11-4	The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance (full definitions and explanations are available in the referenced sections): 1. Misrepresentation and false advertising of insurance policies 2. False information and advertising generally 3. Defamation 4. Boycott, coercion and intimidation 5. False statements and entries 6. Stock operations and advisory board contracts as an inducement to insurance 7. Unfair discrimination 8. Rebates 9. Unfair claim settlement practices 10. Failure to maintain complaint handling procedures 11. Misrepresentation in insurance applications 12. Failure to maintain privacy of consumer financial and health information
Standards for the Acknowledgment of Pertinent Communications	§114-14-5	1. Acknowledgment of notices of claims – within 15 working days 2. Answer of inquiries from insurance department – within 15 working days 3. Replies to other pertinent communications – within 15 working days 4. Provisions of assistance to first party claimants – Provide necessary claim forms, instructions, and reasonable assistance within 15 working days of notification of a claim.

Unfair Trade Practices	REFERENCE	COMMENTS
Standards for Prompt Investigations and Fair and Equitable Settlements Applicable to All Insurers	§114-14-6	All insurers must comply with the following (full explanations are available in the Regulation) 1. Investigation of Claims – Investigation must commence within 15 working days of receiving notice of the claim. Must provide a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant within 15 working days of receiving notice of the claim. 2. Offers of Settlement – In cases where there is no dispute over coverage or liability, it is the duty of the insurer to offer claimants amounts which are fair and reasonable as shown by its investigation of the claim, providing the amounts offered are within policy limits and provisions. 3. Denial of Claims – No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision, condition or exclusion is included in the denial. 4. Records of Denial of Claims – If a denial is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer. 5. Notice of Necessary Delay in Investigating Claims – If the insurer needs more time with a claim, it shall notify the claimant in writing within 15 working days after receipt of the proofs of loss. If the investigation remains incomplete, the insurer shall send notification to the claimant every 45 days thereafter until the investigation is completed. The letter shall contain a reason for additional time. 6. Liability of Others – Insurers may not refuse to settle claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions. 7. Denial of Claims for Failure to Exhibit Property – No insurer shall deny a claim for failure to exhibit the insured property without proof of demand by the insurer and refusal by the claimant to exhibit the property. 8. Separation of Claims – If there is no dispute as to one or more elements of a claim, payment for such element(s) shall be made notwithstanding the existence of disputes as to other elements of the claim if payment can be made without prejudice to either party.

Unfair Trade Practices	REFERENCE	COMMENTS
Standards for Prompt Investigations and Fair and Equitable Settlements Applicable to All Insurers	§114-14-6	9. Time for Payment of Claims – Insurers must pay the amount agreed upon no later than 15 working days from the receipt of the agreement or from the date of the performance by the claimant of any condition set by such agreement, whichever is later. 10. Notice of Applicable Time Limitations – No person shall negotiate for settlement of a claim with a claimant who is neither an attorney nor represented by an attorney without giving the claimant written notice that the claimant's rights may be affected by a statute of limitations or a policy or contract time limit. Such notice shall be given to first party claimants 30 days before, and to third party claimants 60 days before the date on which the time limit may expire. 11. Avoidance of Payment – Where liability and damages are reasonably clear, no person shall recommend that third party claimants make claim under their own policies solely to avoid paying claims under an insurer's insurance policy or insurance contract. 12. Unreasonable Travel – No person shall require a claimant to travel unreasonably to either inspect a replacement motor vehicle or to obtain a repair estimate.

Medical Malpractice		
REVIEW REQUIREMENTS	**REFERENCE**	**COMMENTS**
RATES		
Rate Filing	**REFERENCE**	**COMMENTS**
Fee, filing	§33-6-34	The Filing Fee is $75.00 per Rate filing and $75.00 per Rule filing and applies on a per company basis.
Submission, filing	WVIL (Informational Letter) 163	All filings **must** be submitted through SERFF (System for Electronic Rate and Form Filing). Filing fees **must** be remitted via EFT (Electronic Funds Transfer) through SERFF.
Basic Requirements	§33-20B-4(a)	**On or before the first day of July each year every insurer offering malpractice insurance shall make a rate filing,** regardless of whether any increase or decrease is indicated. The information furnished in support of a filing shall include: (i) The experience or judgment of the insurer or rating organization making the filing; (ii) its interpretation of any statistical data the filing relies upon; (iii) the experience of other insurers or rating organizations; (iv) the character and extent of the coverage contemplated; (v) the proposed effective date of any requested change and (vi) any other relevant factors required by the commissioner.

WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER
Medical Malpractice Insurance Review Standards Checklist

Rate Filing	REFERENCE	COMMENTS
Abstract	§114-67	File Appropriate Abstract. Available in Regulations-Series 67. Appendix E (Loss Cost)- PCA-LCR-2009 and/or Appendix F (Rate/Rule)- PCA-R-2009
Waiting Period	§33-20B-3(b)	Every filing shall be on file for a waiting period of ninety days before it becomes effective. The commissioner may extend the waiting period for an additional thirty days upon written notice that additional time for the consideration of the filing is necessary. Upon written notification the commissioner may authorize a filing which has been reviewed to become effective before the expiration of the waiting period or extension. A filing shall be deemed to meet the requirements of this article unless disapproved by the commissioner within the waiting period or any extension thereof.
Suggested Lead Time for filings	§33-20B-3(B)	Should be filed at least ninety days prior to either the effective date requested or to the date that our final disposition needs to be known.
Rating Organizations	§33-20-4(c)	An insurer may, but is not required to, satisfy its obligation to make such filing by becoming a member of or a subscriber to a licensed rating organization which makes such filings and by authorizing the commissioner to accept such filings on its behalf.
Filing Requirements for Members of Rating Organizations	§33-20-7(b), *WVIL* 54	If a member or subscriber deviates in any way from the approved rating organization filing, the insurer must make written application to the commissioner for permission to file a deviation from the class rates, schedules, rating plans or rules respecting any kind of insurance, or class of risk within a kind of insurance or a combination thereof. This application must specify the basis for modification and a copy must also be sent simultaneously to such rating organization. The commissioner will give consideration to the available statistics and the applicable principles for rate making as provided in §33-20-3. Initial or amended loss cost multipliers or modifiers must be filed independently. The following will be considered deviations: 1. Use of rates higher or lower than those approved for the rating organization. 2. Non-adoption of an approved rating organization filing. 3. Delay in the implementation of an approved rating organization filing. 4. Modification of a deviation currently in use.
Required Hearing for 10% or Higher	§33-20B-4(d)	Within the initial 90 day waiting period, the commissioner shall hold a public hearing upon every filing which requests an increase in general rates of ten percent or more and upon every filing which, in the commissioner's opinion, is of such import that it will affect the public. The insurer or rating organization will be notified not less than 15 days prior to the hearing date. Notice of the time, place and filing to be considered shall be published as a Class II legal advertisement in every county in the state in accordance with §59-3-1 et seq.

Requirements	REFERENCE	COMMENTS
Consent-to-Rates and Guide "A" Rates	§114-59-3(3.1)	Any insurer that wishes to negotiate consent to rate agreements or apply guide “a” rates in connection with the issuance or renewal of medical malpractice, shall first file with the commissioner, an appendix which describes the specific risks or reasons for which non-standard rates will be applied to particular risks. The appendix must also set forth the ranges of rates that will be applied to risks that may be the subject of consent to rate agreements: *Provided,* that the appendix is not required to include rate ranges that will apply to guide “a” rates.
	§114-59-3(3.2)	An insurer shall obtain from the applicant all information necessary to determine the proper application of a non-standard rate before seeking approval from the commissioner of a consent to rate agreement or guide “a” rate. The application for approval of a consent to rate agreement or the use of a guide “a” rate in connection with a specific risk shall be signed by the insured and the insurer, and shall be submitted by the insurer on the West Virginia Medical Malpractice Policy Agreement form, Appendix A to rule §114CSR59. The original and one copy of the application shall be filed and shall be accompanied by a filing fee of $25.00 and a self-addressed postage prepaid envelope. Resubmission of a disapproved filing will require an additional filing fee. The filing fee shall be paid by the insurer and may not be passed on to the insured.
	§33-20B-2(e)	An insurer may use guide "A" rates and other non-approved rates, also known as "consent to rates": Provided, That the insurer shall, prior to entering into an agreement with an individual provider or any health care entity, submit guide “A” rates and other non-approved rates to the commissioner for review and approval
Disapproval	§§33-20B-4	During the waiting period, if the commissioner finds that a filing does not meet all requirements, a written notice of disapproval shall be sent to the insurer specifying in what respects the filing fails to meet the requirements and that such filing shall not be effective. Within 30 days from the issuance of written notice of disapproval, the insurer or rating organization may request a hearing pursuant to §33-2-13.
		If at any time subsequent to initial approval the commissioner finds that a filing does not meet all requirements, a written order shall be sent specifying the reason for the same, and a date, not less than 30 days from the issuance of the order, when the filing shall be deemed no longer effective. Within 30 days from the issuance of such order, the insurer or rating organization may request a hearing thereon pursuant to §33-2-13. Any such order shall not affect any contract or policy made or issued prior to the expiration date set forth in such order.
		Any person or organization aggrieved by any filing may request a hearing pursuant to §33-2-13. The insurer or rating organization which made such filing shall be notified in writing upon receipt of any such request and thereby be made a party to such hearing. Upon the hearing, if the commissioner finds the filing fails to meet all requirements, he shall issue an order pursuant to §33-20B-4(b).