

**WEST VIRGINIA
SECRETARY OF STATE
JOE MANCHIN, III
ADMINISTRATIVE LAW DIVISION**

Form #3

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FILED

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OFFICE WEST VIRGINIA
SECRETARY OF STATE

**NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE**

AGENCY: Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY: WV Code §§33-2-9(n) & 33-2-10

AMENDMENT TO AN EXISTING RULE: YES NO

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 15

TITLE OF RULE BEING AMENDED: ~~Examiners Compensation Qualifications and
Classification~~ Examiners & Examinations

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: _____

TITLE OF RULE BEING PROPOSED: _____

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE FOR THEIR REVIEW.


Authorized Signature

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period, Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: August 26, 2004

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER
ATTN: Legal Division
1124 Smith Street
Post Office Box 50540
Charleston, West Virginia 25305-0540

LEGISLATIVE RULE TITLE: EXAMINERS AND EXAMINATIONS
(TITLE 114, SERIES 15)

1. Authorizing statute(s) citation:

West Virginia Code §§ 33-2-9(n) and 33-2-10

2. a. Date filed in State Register with Notice of Hearing or Public Comment Period:

June 30, 2004 - Comment Period.

b. What other notice, including advertising, did you give of the hearing?

None

c. Date of Public Hearing(s) or Public Comment Period ended:

Comment period ended July 30, 2004.

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached X No comments received

**e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing:
(be exact)**

August 26, 2004

- f. Name, title, address and phone/fax/e-mail numbers of agency person(s) to receive all written correspondence regarding this rule: (Please type)**

Mary Jane Pickens, General Counsel
West Virginia Insurance Commission
Legal Division
P.O. Box 50540
Charleston, WV 25305-0540
Phone: (304) 558-0401
Fax: (304) 558-1362
E-mail: MJ.Pickens@wvinsurance.gov

- g. IF DIFFERENT FROM ITEM 'f', please give Name, title, address and phone number(s) of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)**

Not applicable

- 3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:**

- a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.**

Not applicable

- b. Date of hearing or comment period:**

Not applicable

- c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?**

Not applicable

- d. Attach findings and determinations and reasons:**

Not applicable

ATTACHMENT TO QUESTION 2 (d):

Two sets of comments were received during the comment period in response to the proposed legislative rule entitled "Examiners and Examinations": one sent on behalf of The West Virginia HMO Association and one on behalf of America's Health Insurance Plans ("AHIP").

A. West Virginia HMO Association – Letter dated July 30, 2004

The HMO Association offered comments on proposed amendments to Series 15 by letter dated July 30, 2004. The first comment is that subdivisions (a), (b) and (c) of subsection 4.2, subsection 4.3, and subsection 4.6 apply to health insurers but should also include HMOs. The Commissioner agrees with this comment and a definition will be added to section 2 of the rule to clarify that "insurer" will include other entities within the scope of the rule unless otherwise specified. In addition, subdivisions (a), (b) and (c) of subsection 4.2 and subsection 4.3 will be changed as set forth below. The HMO Association further comments that with regard to subsection 4.6, the time period for maintaining complaint and grievance logs should be changed to 3 years for HMOs rather than 5 years based upon W. Va. Code Section 33-25A-12(k). As an alternative, the HMO Association suggests a transition plan for implementation of a 5 year requirement. The Commissioner agrees to clarify the periods of time that insurers must retain records in order to avoid inconsistencies with the Code.

The new definition discussed above will be added as a new subsection 2.13 to read as follows, and the remaining subsections of section 2 will be renumbered:

2.13. "Insurer" as used in this rule, means any entity covered by the scope of this rule pursuant to subdivision c, subsection 1.1 of this rule, unless otherwise specified herein.

Based upon the discussion above, subdivisions (a), (b) and (c) of subsection 4.2, subsection 4.3, and subsection 4.6 will be changed to read as follows:

4.2. For the purpose of examination, analysis and review activities conducted pursuant to W. Va. Code §33-2-9 or this rule, an insurer or related entity licensed to do business in this state shall maintain its books, records and documents in a manner so that the commissioner can readily ascertain during an examination the insurer's compliance with the insurance laws and rules of this state, the standards outlined in the NAIC Financial Conditions Examiner Handbook, and with the standards outlined in the NAIC Market Conduct Examiners Handbook, including, but not limited to, company operations and management, policyholder service, marketing, producer licensing, underwriting, rating, complaint/grievance handling, and claims practices.

a. For an insurer subject to 114CSR51 or 114CSR53, the insurer or related entity shall, in addition, maintain its books, records, and documents in a manner so that the practices of the entity regarding network adequacy, utilization review, quality assessment and improvement and provider credentialing may be ascertained during a market conduct examination.

b. All insurer records within the scope of this rule must be retained for the lesser of:

1. The current calendar year plus five (5) calendar years;
2. From the closing date of the period of review for the most recent examination by the commissioner; or
3. A period otherwise specified by statute as the examination cycle for the insurer.

c. The producer of record shall maintain a file for each policy sold, and the file shall contain all work papers and written communications in his or her possession pertaining to the policy documented therein. These records shall be retained for the current calendar year plus additional years as set forth in subdivision b of this subsection.

4.3. All policy record files shall be maintained for each policy issued, and shall be maintained for the duration of the current policy term plus additional years as set forth in subdivision b, subsection 4.2 of this section: *Provided, That for life insurance policies and annuity contracts, such files must be maintained from the original inception date of the policy or contract through termination, plus additional years as set forth in subdivision b, subsection 4.2 of this section. Policy records shall be maintained so as to show clearly the policy period, basis for rating and any imposition of additional exclusions from or exceptions to coverage. If a policy is terminated, either by the insurer or the policyholder, documentation supporting the termination and account records indicating a return of premiums, if any, shall also be maintained. Policy records need not be segregated from the policy records of other states so long as the records are readily available to market conduct examiners as required under this rule.*

4.6. The complaint records required to be maintained shall include a complaint log or register, or grievance log or register for health insurers, in addition to the actual written complaints or grievances. The complaint log or register shall show clearly the total number of complaints for the period of time set forth in subdivision b, subsection 4.2 of this section, the classification of each complaint by line of insurance and by complainant, for example the insured, the commissioner, a third party, etc., the nature of each complaint, the insurer's disposition of each complaint, and the complaint number assigned by the commissioner, if applicable. If the insurer maintains the file in a computer format, the reference in the complaint log or register for locating the documentation shall be an identifier such as the policy number or other code. The codes shall be provided to the examiners at the time of an examination.

Other instances of reference to the 5 year retention period not mentioned by either entity offering comments on the proposed amendments to Series 15 are found in subdivisions 4.3(b) and 4.4(a). Those sections will be changed to read as follows:

4.3.

b. A declined underwriting file shall be maintained and shall include an application, any documentation supporting the decision to decline an issuance of a policy, any binder issued without the insurer issuing a policy, any documentation supporting the decision not to add additional coverage when requested and, if required by law, any declination notification. Notes regarding requests for quotations that do not result in a completed application for coverage need not be maintained for purposes of this rule.

4.4. *Claim files shall be maintained as follows:*

a. A claim file and accompanying records shall be maintained for the calendar year in which the claim is closed plus additional years as set forth in subdivision b, subsection 4.2 of this section. The claim file shall be maintained so as to show clearly the inception, handling and disposition of each claim. The claim files shall be sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed. A claim file shall, at a minimum, include the following items:

The HMO Association has further commented that the definition of complaint and grievance in the proposed amendments are contrary to recently issued Informational Letter 100A. Consequently, the HMO Association says that the rule should be amended to not apply to HMO's or corrected to be consistent with Informational Letter 100A. The Commissioner disagrees that the changes suggested by the HMO Association are necessary. The intent of the proposed amendments to Series 15 is only to put into place record retention requirements. It is important to note that the rule applies to other entities than HMO's. The definition of complaint or grievance must apply to all entities covered by the rule. However, the definition is not inconsistent with Informational Letter 100A. Informational Letter 100A was intended to clarify the methods under which formal and informal grievances are reported to the Commissioner and the circumstances under which corrective action plans are required under 114CSR53. Informational Letter 100A further defines complaints and grievances as they relate to the reporting requirements that are peculiar to HMO's.

The next comment of the HMO Association is that subdivision 4.9(a) requires an HMO to provide requested documents within 5 working days, and that this may be unreasonable since often documents are stored off-site. The Commissioner does not agree that this provision is unreasonable or burdensome. This subdivision only addresses supplementary data requests by the examiner after the examination has begun or requests for documents needed to clarify or resolve a question of fact regarding a document or file the company has already produced. The Commissioner as a matter of course sends "call letters" out 60 days in advance of the beginning of an examination, which will

clearly define the scope of the examination. In addition, the initial data request is sent to companies 30 days in advance of the examination. Finally, there is a caveat that allows the documents to be provided under that subdivision within some other period of time as agreed upon by the examiner and the insurer, if 5 days is insufficient time.

The final comment of the HMO Association is that HMO's are accredited and therefore audited annually on quality, appeals, credentialing, etc. The HMO Association states that these new requirements are duplicative and burdensome. The Commissioner does not agree. The amendments are for record retention. The Commissioner's examination duty is set forth in W. Va. Code Section 33-25A-17 and 33-2-9. The Commissioner cannot fail to conduct examinations just because the HMO's are accredited – it is required by statute. In addition, financial and market conduct examinations are considerably more thorough than accreditation audits and more protective of consumers in this State. Series 15 will assist with the statutorily required examinations, and are a necessary part of a meaningful examination program.

B. America's Health Insurance Plans ("AHIP") – Letter dated July 30, 2004.

AHIP offered several comments on the proposed amendments to Series 15 that were the same or similar to those offered by the HMO Association. The first comment is that subdivision 4.2(a) appears to apply to all insurers, however not all insurers are subject to standards for network adequacy, utilization review, and quality assessment and improvement. The Commissioner agrees with this comment and refers AHIP to the changes set forth above in response to comments offered by the HMO Association.

The next comment offered by AHIP is that subdivision 4.2(b) and subsections 4.3, 4.4 and 4.6 contain a 5 year requirement for which there is no statutory authority. The Commissioner disagrees that there is no statutory authority for the requirement that insurers maintain records for some period of time. W. Va. Code Section 33-2-9 requires the Commissioner to examine companies under that section as often as she considers appropriate, but at least every 5 years (other appropriate Code sections may have different time periods for examination, for example every 3 years for HMO's and every 4 years for health service corporations). W. Va. Code Section 33-2-9(i)(2) states that every company or person from whom information relating to an examination is sought must provide to the examiners timely, convenient and free access at all reasonable hours to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. Clearly, the Legislature intended that records be retained so that they can be produced for examinations. Any concerns about the 5 year requirement and its relationship to the differing examination cycles established by statute have been addressed as set forth in the responses above to the HMO Association comments.

AHIP's next comment is that subsection 4.5 establishes a record retention policy for complaints and grievances but there is no statutory authority for maintaining information about complaints and grievances outside of Article 25A of Chapter 33. The Commissioner disagrees. W. Va. Code Section 33-11-4(10) requires an insurer to maintain a complete record for all complaints

which it has received since the date of its last examination under W. Va. Code Section 33-2-9. Therefore the Commissioner declines to make any changes based upon this comment.

AHIP further comments that subsection 4.9 requires an insurer to provide information within 5 working days. As explained in response to the HMO Association comments, perhaps there is a misunderstanding regarding this subsection, which only deals with data requests after the examination has been initiated. The Commissioner declines to make any changes to this subsection because it allows for a longer period of time by agreement if records are not stored on-site.

The final comment offered by AHIP is that the 5 year record retention requirement be phased in because some companies will not be able to immediately comply with it. The Commissioner believes that this concern has been addressed by the proposed changes to subdivision 4.2(b) set forth above in response to the HMO Association comments.

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LEGAL DIV.
WV INS. DEPT.



SPILMAN THOMAS & BATTLE, PLLC

ATTORNEYS AT LAW

(304) 340-3829
tcox@spilmanlaw.com

July 30, 2004

HAND-DELIVERY

Mary Jane Pickens, Counsel
West Virginia Insurance Commission
1124 Smith Street
P. O. Box 50540
Charleston, West Virginia 25305-0540

Re: Comments to Series 15 and Series 67

Dear Ms. Pickens:

These comments are submitted on behalf of America's Health Insurance Plans ("AHIP") to Series 15 proposed regulations which amend "Examiners Compensation Qualifications and Classification Examiners and Examination" and Series 67 dealing with "Rate and Form Filing, Abstracts." AHIP is the national trade association representing nearly 1,300 member companies providing health insurance coverage to more than 200 million Americans.

SERIES 15

Our comments about the proposed changes to Series 15 are as follows:

1. Section 4.2(a) requires a health insurer to maintain its records "among other things" for "network adequacy," "utilization review," and "quality assessment and improvement." Health maintenance organizations are the only insurers with statutory requirements involving quality assessment, network adequacy and utilization review. In fact, the West Virginia Code is silent on these requirements for non-HMO's. These requirements appear to be beyond the scope of authority contained in Chapter 33 and request information for which there are no standards under West Virginia law. In the absence of statutory or regulatory requirements concerning these practices, for what purpose would a health insurer that is not an HMO maintain these records? These requirements as they apply to non-HMO health insurers should be deleted.

2. Sections 4.2(b), 4.3, 4.4 and 4.6 require a health insurer to maintain its records for five years. This is a new standard for which there does not appear to be any statutory authority.

3. Section 4.5 establishes a record retention policy for complaints and grievances. The only specific statutory authority for maintaining information about complaints and grievances is contained in Article 25A which deals with HMO's. Articles 15, 15A, 15B, 16, 16A, 16B and 16D are silent on this issue. Accordingly, there is no statutory requirement involving complaints or grievances for non-HMO's. These requirements are beyond the

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Mary Jane Pickens, Counsel
West Virginia Insurance Commission
July 30, 2004
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authority contained in the West Virginia Code and should not be required for non-HMO health insurers.

4. Section 4.9 requires an insurer to provide information within five working days. In many cases, these records will be stored off-site. This short time frame may place an undue burden on an insurer, and we would ask that it be increased to a more reasonable time frame.

5. In the alternative, companies will not be able to meet this five-year policy immediately because they have not been required to maintain records for any specific length of time. The requirement should be phased in beginning upon the effective date of this regulation.


SERIES 67

The Series 67 proposed regulations introduced by the Insurance Commissioner deal with "Rate and Form Filing, Abstracts." Under the current regulations, group health insurance policies which are "negotiated and experience rated" are not subject to these filing requirements. This exception is established pursuant to W. Va. Code § 33-16B-3. Further, the current regulations define "experience rated groups." The proposed regulations appear to eliminate this exception.

The underlying legal authority for this exception still exists. For clarification purposes, the current exception for negotiated and experience rated groups should be specifically included in the proposed regulations. Group health policies which are negotiated and experience rated should not be required to submit a rate abstract for approval by the Commissioner.

AAHP-HIAA greatly appreciates the consideration of its comments. If you have any questions, please do not hesitate to contact me.

Sincerely yours,


T. Randolph Cox
Counsel, AHIP

TRC/lb;317548

cc: Jeffrey E. Tindall



SPILMAN THOMAS & BATTLE, PLLC
ATTORNEYS AT LAW

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JUL 30 04

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July 30, 2004

Mary Jane Pickens, Counsel
West Virginia Insurance Commission
1124 Smith Street
P. O. Box 50540
Charleston, West Virginia 25305-0540

Re: Comments to Series 15, Series 67, Series 71

Dear Ms. Pickens:

These comments are submitted on behalf of the West Virginia HMO Association to Series 15, Series 67 and series 71. The HMO Association is a state trade association consisting of the four licensed HMO's in West Virginia.

SERIES 15

Series 15 deals with amendments to the "Examiners Compensation Qualifications and Classification Examiners and Examination."

1. Section 4.2(a), (b) and (c), Section 4.3, and Section 4.6 require an insurer to maintain records for a period of five calendar years. These sections apply to health insurers. It appears that a health insurer should include health maintenance organizations.

Section 4.6 specifically applies to, among other things, complaint and grievance logs. West Virginia Code § 33-26A-12(k) provides that grievances and responses thereto shall be maintained for a period of three (3) years. The requirements of these sections are in conflict with the HMO Act and should be changed to three years for HMO's.

In the alternative, the five year requirement is a significant departure from the three year retention requirement currently employed by HMO's. At a minimum if this requirement is not amended to three years for HMO's, there should be a transition plan allowed for implementation.

2. Some of the definitions contained in this series concerning complaints and grievances are contrary to recently issued information letter 100A. This new information letter was a subject of much discussion between the Insurance Department and the WV HMO

Mary Jane Pickens, Counsel
West Virginia Insurance Commission
July 30, 2004
Page 2

Association. The provisions of this section should be amended to not apply to HMO's or corrected to be consistent with Information Letter 100A.

3. Section 4.9(a) requires an HMO to provide any requested document within five working days. This time frame is unreasonable. These documents may be stored off-site. This will place an unnecessary burden and cost on HMO's to comply with this time frame. This time frame should be extended to a more reasonable time frame.

4. Finally, unlike other health insurers, HMO's are required to be accredited. They are audited annually on quality, appeals, credentialing, etc. These new requirements are expensive and duplicative. These additional administrative expenses will be borne ultimately by the consumer through increased rates. The Association would ask if the Department would consider some relief on these requirements given the already heavy regulatory burden on HMO's.

SERIES 67

The Series 67 proposed regulations introduced by the Insurance Commissioner deal with "Rate and Form Filing, Abstracts." Under the current regulations, group health insurance policies which are "negotiated and experience rated" are not subject to these filing requirements. This exception is established pursuant to W. Va. Code § 33-16B-3. Further, the current regulations define "experience rated groups." The proposed regulations appear to eliminate this exception.

The underlying legal authority for this exception still exists. For clarification purposes, the current exception for negotiated and experience rated groups should be specifically included under the proposed regulations. Group health policies which are negotiated and experience rated should not be required to submit a rate abstract for approval by the Commissioner.

SERIES 71

Proposed Series 71 are entitled "Insurance Fraud Prevention." The proposed regulations reference the NAIC model Fraud Reporting Form (114-71-3.5). The current form is not attached to the regulations. For purposes of convenience, it might be helpful if the current form is attached to this regulation and/or information where the current forms may be found be included with this regulation.

 SPILMAN THOMAS & BATTLE, P.L.L.C.
ATTORNEYS AT LAW

Mary Jane Pickens, Counsel
West Virginia Insurance Commission

July 30, 2004

Page 3

Thank you for your consideration of our comments. If you have any questions, please contact me.

Sincerely yours,



T. Randolph Cox
Counsel, West Virginia HMO Association

TRC/lb;317521

cc: Patrick W. Dowd
John A. Bellante
Philip W. Wright
John M. Collins

**Insurance Commissioner
Legislative Rule
Title 114, Series 15**

**EXAMINERS AND EXAMINATIONS
TITLE 114, SERIES 15**

BRIEF SUMMARY OF RULE

This rule is being amended to remove certain provisions relating to travel reimbursement and travel approval for the Insurance Commissioner's examiners and replace them with provisions that are more consistent with the Governor's Travel Rules, to which other Insurance Commission personnel are subject. The amendments will also clarify that the Insurance Commissioner's market conduct examiners are subject to the rule in addition to her financial examiners, and will add to section four of the rule several subsections relating to the kinds of records that must be retained for market conduct examination purposes, the period of time that they must be retained, and how and where the records may be stored and located. These records are necessary to conduct a thorough market conduct examination of the companies, and the addition of these amendments will set the standards for record retention, which are currently not collected in one place in the code and rules. The amendments will also require companies to produce the records to the examiners within five working days or within such other time that is agreed upon.

**Insurance Commissioner
Legislative Rule
Title 114, Series 15**

EXAMINERS AND EXAMINATIONS

TITLE 114, SERIES 15

STATEMENT OF CIRCUMSTANCES

This rule is being amended to remove some out-of-date provisions relating to travel reimbursement and travel approval that were included in the rule at a time when the Insurance Commissioner contracted with examiners from outside West Virginia to perform examination work on companies domiciled in West Virginia. Often these contracted examiners had residences in distant states, and there was a need to very closely control the travel and expenses of these examiners to ensure that no advantage was being taken by them in relation to travel and reimbursement. The Insurance Commissioner has added staff examiners in the last three years and the need for examinations to be conducted primarily by contracted examiners has lessened. There is no longer a need to subject examiners on the Insurance Commissioner's staff to a different set of travel and reimbursement rules than other staff members. The amendments will therefore make the staff examiners subject to the Governor's Travel Rules as the primary controlling set of rules relating to their travel and reimbursement. The amendments will also clarify that market conduct examiners are subject to the rule in addition to financial examiners, and will add to section four of the rule several subsections relating to the records that must be retained for market conduct examination purposes and the period of time that they must be retained. These records are necessary to conduct a thorough market conduct examination of the companies, and the addition of these amendments will set the standards for record retention. The amendments will also require companies to produce the records to the examiners within five working days or within such other time that is agreed upon. These are substantive changes to the rule that are appropriate under the Insurance Commissioner's general rule making authority found at W.Va. Code §33-2-10, as a measure that will "protect and safeguard the interests of policyholders and the public of this State."

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: EXAMINERS AND EXAMINATIONS
Title 114, Series 15

Type of Rule: X **Legislative** **Interpretive** **Procedural**

Agency: Insurance Commissioner

Address: Post Office Box 50540
1124 Smith Street, Greenbrooke Building
Charleston, West Virginia 25305-0540

=====

1. Effect of Proposed Rule

	ANNUAL FISCAL YEAR				
	Increase	Decrease	Current	Next	Thereafter
ESTIMATED TOTAL COST	None	None	None	None	None
PERSONAL SERVICES	None	None	None	None	None
CURRENT EXPENSE	None	None	None	None	None
REPAIRS AND ALTERNATIONS	None	None	None	None	None
EQUIPMENT	None	None	None	None	None
OTHER	None	None	None	None	None

2. Explanation of above estimates:

The rule will have no additional fiscal impact upon state government.

Rule Title: EXAMINERS AND EXAMINATIONS
Title 114, Series 15

3. Objectives of these rules:

The objectives of the amendments to this rule are to clarify that market conduct examiners are subject to the rule in addition to the Insurance Commissioner's financial examiners and to make the travel and reimbursement for the Commissioner's staff examiners more consistent with her other staff. The objectives will be achieved by removing some out-of-date provisions relating to travel reimbursement and travel approval that were included in the rule at a time when the Insurance Commissioner contracted with examiners from outside West Virginia to perform examination work on companies domiciled in West Virginia. During those years there was a need to very closely control the travel and expenses of these examiners to ensure that no advantage was being taken by them in relation to travel and reimbursement because of their situation of living in distant states. The Insurance Commissioner has added staff examiners in the last three years and the need for examinations to be conducted primarily by contracted examiners has lessened. There is no longer a need to subject examiners on the Insurance Commissioner's staff to a different set of travel and reimbursement rules than other staff members. The amendments will therefore make the staff examiners subject to the Governor's Travel Rules as the primary controlling set of rules relating to their travel and reimbursement. Additional objectives are to add to section four of the rule several subsections relating to the records that must be retained for market conduct examination purposes and the period of time that they must be retained. These records are necessary to conduct a thorough market conduct examination of the companies, and the addition of these amendments will set the standards for record retention. The amendments will also require companies to produce the records to the examiners within five working days or within such other time that is agreed upon.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None anticipated. The Insurance Commissioner's staff is currently performing market conduct and financial examinations, and the amendments to this rule will not alter the reimbursement amounts for travel that are already in place. The amendments to this rule do not place any additional burden on the Insurance Commissioner's budget.

Rule Title: EXAMINERS AND EXAMINATIONS
Title 114, Series 15

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

The amendments to this rule are not expected to have an economic impact on political subdivisions or specific groups of citizens. Although the rule amends some substantive provisions relating to the examinations themselves by adding record retention requirements, large insurance companies doing business in multiple states are already subject to these requirements in many states. West Virginia's domestic companies are already retaining records for examination purposes so these changes should not present a costly implementation issue for them. The record retention requirements are intended to produce consistency among companies and better enable the Insurance Commissioner to conduct effective examinations.

C. Economic Impact on Citizens/Public at Large.

There should be no specific economic impact on the public.

Date: August 26, 2004

Signature of Agency Head or Authorized Representative


Jane L. Cline, Insurance Commissioner

114CSR15

LEGISLATIVE RULE
INSURANCE COMMISSIONER
SERIES 15

~~EXAMINERS' COMPENSATION, QUALIFICATIONS AND
CLASSIFICATION~~
EXAMINERS AND EXAMINATIONS

Section

- 114-15-1. General.
- 114-15-2. Definitions.
- 114-15-3. Examination, Analysis and Review Funding.
- 114-15-4. Examination, Analysis, ~~and~~ Review Activities and Record Retention Requirements.
- 114-15-5. Contracts for Services and Bond Requirements for Other Individuals.
- 114-15-6. Compensation and Accrued Time of Accredited Examiners.
- 114-15-7. Travel and Living Expenses.
- 114-15-8. Examiner Reporting Requirements.

114CSR15

LEGISLATIVE RULE
INSURANCE COMMISSIONER
SERIES 15

~~EXAMINERS' COMPENSATION, QUALIFICATIONS AND
CLASSIFICATION~~
EXAMINERS AND EXAMINATIONS

FILED
2004 AUG 26 P 2:38
OFFICE WEST VIRGINIA
SECRETARY OF STATE

§114-15-1. General.

1.1. Scope. --This legislative rule establishes:

a. ~~standards~~ Standards for the compensation, qualifications and classification of persons who conduct or participate in any analysis, review or examination provided for in W. Va. Code §33-2-9; and

b. Standards for retention of records and documents that the commissioner may require to be produced by an insurer in connection with any analysis, review or examination provided for in W. Va. Code §33-2-9.

c. This rule applies to all insurers authorized to transact insurance in this state by the commissioner, health maintenance organizations, hospital, medical, dental and health service corporations, health care corporations, fraternal benefit societies, and prepaid limited health service organizations.

1.2. Authority. -- W. Va. Code §§33-2-9(n) and 33-2-10.

1.3. Filing Date. -- ~~April 3, 2003.~~

1.4. Effective Date. -- ~~April 3, 2003.~~

§114-15-2. Definitions.

As used in this legislative rule:

2.1. "Accredited examiner" or "examiner" means a person who is an employee of the insurance commissioner ~~and has been classified according to his or her qualifications as either~~ whose principle duty is to conduct, supervise, or provide technical support for financial or market conduct examinations, including but not limited to the following division of personnel job classifications: insurance company examiner, or insurance company examiner supervisor, market conduct examiner, market conduct examiner supervisor, or computer audit specialist,

**Insurance Commissioner
Legislative Rule
Title 114, Series 15**

pursuant to the classification plan of the West Virginia division of personnel or such other equivalent classification plan as the state of West Virginia may adopt.

2.2. “Additional examination assessment fee” means any additional or increased examination assessment fee levied by order of the commissioner in excess of the annual examination assessment fee as allowed by the provisions of W. Va. Code §33-2-9.

2.3. “Application and accompanying records” means any written or electronic application form, any enrollment form, any document or record thereof, used to add coverage under any existing policy, questionnaire, telephone interview form, paramedical interview form or any other document used to question or underwrite an applicant for any policy issued by an insurer or for any declination of coverage by an insurer.

~~2.4. “Deputy” means any individual appointed by the commissioner as Deputy or Special Deputy Commissioner of Insurance.~~

2.4. “Claim file and accompanying records” means the file maintained so as to show clearly the inception, handling and disposition of each claim. The claim file shall be sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed.

~~2.3.~~ 2.5. “Commissioner” means the insurance commissioner of the state of West Virginia.

2.6. “Complaint” means a written communication primarily expressing a grievance.

2.7. “Declination” or “declined underwriting file” means all written or electronic records concerning coverage for which an application has been completed and submitted to the insurer or its producer but the insurer has made a determination not to issue a policy or not to add additional coverage when requested.

~~2.5.~~ 2.8. “Examination assessment fee” means the annual fee due on or before the first day of July of every year, as specified in W. Va. Code §33-2-9.

~~2.6.~~ 2.9. “Governor’s travel rules” means those rules promulgated by the governor pursuant to the authority granted by W. Va. Code §12-3-11.

2.10. “Grievance” for health insurance purposes, means a written complaint submitted by or on behalf of a covered person regarding the:

a. Availability, delivery or quality of health services, including a complaint regarding an adverse determination made pursuant to utilization review;

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b. Claims payment, handling or reimbursement for health care services; or

c. Matters pertaining to the contractual relationship between a covered person and a health carrier.

~~2.7~~ 2.11. “Incidental expense” means any reasonable travel-related expense other than charges for lodging, meals or mileage, including but not limited to tolls, parking, gratuities or public transportation.

2.12. “Inquiry” means a specific question, criticism or request made in writing to an insurer by an examiner.

2.13. “Insurer” as used in this rule, means any entity covered by the scope of this rule pursuant to subdivision c, subsection 1.1 of this rule, unless otherwise specified herein.

~~2.8:~~ 2.14. “Lodging” means a temporary place of abode, such as a hotel, maintained by the examiner for the convenience of being closer to the examination site, and at which the examiner has no intention of establishing residence.

~~2.9:~~ 2.15. “On-site” or “site” means at or conveniently proximate to the business location of the entity being examined, as listed on the examiner’s semi-monthly days worked report, but does not include the offices of the insurance commissioner when work related to an examination is performed there.

~~2.10:~~ 2.16. “Other employee” means any individual who is an employee of the offices of the insurance commissioner of West Virginia, excluding the commissioner’s accredited examiners.

~~2.11:~~ 2.17. “Other individual or entity” means any individual, corporation, partnership or other business entity that is not an employee of the offices of the insurance commissioner, to include but not be limited to independent certified public accountants, independent actuaries, qualified insurance examiners, reinsurance examiners, investment or information systems specialists or other individuals, corporations, partnerships or other business entities with particular skills or areas of expertise, considered competent by the commissioner to conduct or participate in any examination, analysis or review as allowed by W. Va. Code §33-2-9 or this rule.

2.18. “Related entity” means a person authorized to act on behalf of the insurer in connection with the business of insurance.

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~~2.12:~~ 2.19. "Residence" means a permanent or semi-permanent place of abode, maintained solely for the convenience of the examiner and not in connection with an on-site examination assignment, including the examiner's domicile and any temporary residence established by the examiner.

§114-15-3. Examination, Analysis and Review Funding.

3.1. Every entity subject to the provisions of W. Va. Code §33-2-9 shall remit the examination assessment fee specified by the code or as increased by the commissioner on or before the first day of July of each year.

3.2. Every entity subject to the provisions of W. Va. Code §33-2-9 shall remit any additional examination assessment fee ordered by the commissioner on or before the date specified by the order.

3.3. The monies collected by the commissioner from the examination assessment fee and any additional examination assessment fee shall be deposited as specified in W. Va. Code §33-2-9. The monies deposited into the commissioner's examination revolving fund may be used for any of the following:

a. Salaries and expenses of the insurance commissioner's accredited examiners as specified in this rule for any activities conducted pursuant to W. Va. Code §33-2-9 or this rule;

b. Salaries and/or expenses of the insurance ~~Department's~~ commissioner's special deputies or other employees for activities conducted pursuant to W. Va. Code §33-2-9 or this rule;

c. Salaries, contract rates, fees and/or expenses of other individuals or entities for activities conducted pursuant to W. Va. Code §33-2-9 or this rule; and

d. Equipment, supplies, travel, education, and training and other incidental expenses for the commissioner, his or her deputies, other employees and accredited examiners as considered necessary by the commissioner for the performance of the duties and activities conducted pursuant to W. Va. Code §33-2-9 or this rule.

3.4. Other individuals or entities, when authorized in writing by the commissioner, may, and to the extent the commissioner considers necessary, bill and receive payments directly from the entities subject to examination under the provisions of W. Va. Code §33-2-9 and this rule for their work, travel and living expenses at rates approved by the commissioner, while involved in any of the activities set forth in this section.

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§114-15-4. Examination, Analysis, and Review Activities and Record Retention Requirements.

4.1. Examination, analysis and review activities shall include the following as they relate to the operation of entities, individuals or persons subject to the provisions of W. Va. Code §33-2-9:

a. Examination of the financial condition or market conduct practices of the entity, individual or person;

b. On-site analysis or review of any practice or condition affecting the entity, individual or person; and

c. Review of any statements, reports, or reviews of an entity, individual or person's financial condition, performance or market conduct practices including the review or development of any forecasts or projections or any type of filing made or intended to be made with the insurance commissioner. This review shall include but not be limited to the review or investigation of any audited financial report, compilation or review performed by a certified public accountant, actuarial statement or certification, documents submitted in application for licensure or registration in the state, or other matters or materials deemed necessary by the commissioner to fulfill his or her statutory obligations.

~~4.2. Other individuals or entities may, as the commissioner considers necessary, bill and receive payments directly from the entities subject to the provisions of W. Va. Code §33-2-9 and this rule for their work, travel and living expenses at rates approved by the commissioner while involved in any of the activities set forth in this section.~~

4.2. For the purpose of examination, analysis and review activities conducted pursuant to W. Va. Code §33-2-9 or this rule, an insurer or related entity licensed to do business in this state shall maintain its books, records and documents in a manner so that the commissioner can readily ascertain during an examination the insurer's compliance with the insurance laws and rules of this state, the standards outlined in the NAIC Financial Conditions Examiner Handbook, and with the standards outlined in the NAIC Market Conduct Examiners Handbook, including, but not limited to, company operations and management, policyholder service, marketing, producer licensing, underwriting, rating, complaint/grievance handling, and claims practices.

a. For an insurer subject to 114CSR51 or 114CSR53, the insurer or related entity shall, in addition, maintain its books, records, and documents in a manner so that the practices of the entity regarding network adequacy, utilization review, quality assessment and improvement and provider credentialing may be ascertained during a market conduct examination.

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b. All insurer records within the scope of this rule must be retained for the lesser of:

1. The current calendar year plus five (5) calendar years;
2. From the closing date of the period of review for the most recent examination by the commissioner; or
3. A period otherwise specified by statute as the examination cycle for the insurer.

c. The producer of record shall maintain a file for each policy sold, and the file shall contain all work papers and written communications in his or her possession pertaining to the policy documented therein. These records shall be retained for the current calendar year plus additional years as set forth in subdivision b of this subsection.

d. During an examination of the insurer, the insurer shall provide a copy of the written contract entered into with each third party vendor or service provider as requested by an examiner within the time frames set forth in subsection 4.9 of this section.

4.3. All policy record files shall be maintained for each policy issued, and shall be maintained for the duration of the current policy term plus additional years as set forth in subdivision b, subsection 4.2 of this section: Provided, That for life insurance policies and annuity contracts, such files must be maintained from the original inception date of the policy or contract through termination, plus additional years as set forth in subdivision b, subsection 4.2 of this section. Policy records shall be maintained so as to show clearly the policy period, basis for rating and any imposition of additional exclusions from or exceptions to coverage. If a policy is terminated, either by the insurer or the policyholder, documentation supporting the termination and account records indicating a return of premiums, if any, shall also be maintained. Policy records need not be segregated from the policy records of other states so long as the records are readily available to market conduct examiners as required under this rule.

a. Policy records shall include the following:

1. Any application and accompanying records for each contract. The application shall bear a clearly legible means by which an examiner can identify a producer involved in the transaction. The examiners shall be provided with information clearly identifying the producer involved in the transaction.

2. Any declaration pages (the initial page and any subsequent pages), the insurance contract, any certificates evidencing coverage under a group contract, any

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endorsements or riders associated with a policy, any termination notices, and any written or electronic correspondence to or from the insured pertaining to the coverage. If any of these records have already been filed with the commissioner, a separate copy of the record need not be maintained in the individual policy files to which the record pertains, provided it is clear from the insurer's other records or systems that the record applies to a particular policy and that any data contained in the record relating to the policy, as well as the actual policy issued to the insured, can be retrieved or recreated;

3. Any binder; and

4. Any guidelines, manuals or other information necessary for the reconstruction of the rating, underwriting, policy owner service and claims handling of the policy. The maintenance at the site of a market conduct examination of a single copy of each of the above shall satisfy this requirement. These types of records include, but are not limited to, the application, the policy form including any amendments or endorsements, rating manuals, underwriting rules, credit reports or scores, claims history reports, previous insurance coverage reports (e.g. reports obtained from the Medical Information Bureau), questionnaires, internal reports, and underwriting and rating notes.

b. A declined underwriting file shall be maintained and shall include an application, any documentation supporting the decision to decline an issuance of a policy, any binder issued without the insurer issuing a policy, any documentation supporting the decision not to add additional coverage when requested and, if required by law, any declination notification. Notes regarding requests for quotations that do not result in a completed application for coverage need not be maintained for purposes of this rule.

4.4. Claim files shall be maintained as follows:

a. A claim file and accompanying records shall be maintained for the calendar year in which the claim is closed plus additional years as set forth in subdivision b, subsection 4.2 of this section. The claim file shall be maintained so as to show clearly the inception, handling and disposition of each claim. The claim files shall be sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed. A claim file shall, at a minimum, include the following items:

1. For property and casualty: the file or files containing the notice of claim, claim forms, proof of loss or other form of claim submission, settlement demands, accident reports, police reports, adjustors' logs, claim investigation documentation, inspection reports, supporting bills, estimates and valuation worksheets, medical records, correspondence to and from insureds and claimants or their representatives, notes, contracts, declaration pages, certificates evidencing coverage under a group contract, endorsements or riders, work papers,

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any written communication, any documented or recorded telephone communication related to the handling of a claim, including the investigation, payment or denial of the claim, copies of claim checks or drafts, or check numbers and amounts, releases, all applicable notices, correspondence used for determining and concluding claim payments or denials, subrogation and salvage documentation, any other documentation created and maintained in a paper or electronic format, necessary to support claim handling activity, and any claim manuals or other information necessary for reviewing the claim;

2. For life and annuity: the file or files containing the notice of claim, claim forms, proofs of loss, medical records, correspondence to and from insureds and claimants or their representatives, claim investigation documentation, claim handling logs, copies of checks or drafts, check numbers and amounts, releases, correspondence, all applicable notices, and correspondence used for determining and concluding claim payments or denials, any written communication, any documented or recorded telephone communication related to the handling of a claim, including the investigation, and any other documentation, maintained in a paper or electronic format, necessary to support claim handling activity; and

3. For health: the file or files containing the notice of claim, claim forms, medical records, bills, electronically submitted bills, proofs of loss, correspondence to and from insureds and claimants or their representatives, claim investigation documentation, health facility pre-admission certification or utilization review documentation, claim handling logs, copies of explanation of benefit statements, any written communication, any documented or recorded telephone communication related to the handling of a claim, including the investigation, copies of checks or drafts, or check numbers and amounts, releases, correspondence, all applicable notices, and correspondence used for determining and concluding claim payments or denials, and any other documentation, maintained in a paper or electronic format, necessary to support claim handling activity.

b. Where a particular document pertains to more than one file, insurers may satisfy the requirements of this section by making available, at the site of an examination, a single copy of each document.

c. Documents in a claim file received from an insured, the insured's agent, a claimant, the commissioner or any other insurer shall bear the initial date of receipt by the insurer, date stamped in a legible form in ink, in an electronic format, or some other permanent manner. Unless the company provides the examiners with written procedures to the contrary, the earliest date indicated on a document will be considered the initial date of receipt.

d. If an insurer, as its regular business practice, places the responsibility for handling certain types of claims upon company personnel other than its claims personnel, the insurer need not duplicate its files for maintenance by claims personnel. These claims records

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shall be maintained as part of the records of the insurer's operations and shall be readily available to examiners.

4.5. Records to be maintained relating to the insurer's compliance with licensing requirements shall include the licensing records of each producer associated with the insurer. Licensing records shall be maintained so as to show clearly the licensing status of the producer at the time of solicitation, negotiation or procurement, as well as the dates of the appointments and terminations of each producer. A screenprint from the producer database (PDB) may serve to provide adequate proof only of a producer's current licensing status.

4.6. The complaint records required to be maintained shall include a complaint log or register, or grievance log or register for health insurers, in addition to the actual written complaints or grievances. The complaint log or register shall show clearly the total number of complaints for the period of time set forth in subdivision b, subsection 4.2 of this section, the classification of each complaint by line of insurance and by complainant, for example the insured, the commissioner, a third party, etc., the nature of each complaint, the insurer's disposition of each complaint, and the complaint number assigned by the commissioner, if applicable. If the insurer maintains the file in a computer format, the reference in the complaint log or register for locating the documentation shall be an identifier such as the policy number or other code. The codes shall be provided to the examiners at the time of an examination.

4.7. Records required to be maintained by this rule may be saved as follows:

a. Any record required to be maintained by an insurer may be created and stored in the form of paper, photograph, magnetic, mechanical or electronic medium; or any process that accurately forms a durable reproduction of the record, so long as the record is capable of duplication to a hard copy that is as legible as the original document. Documents that are produced and sent to an insured by use of a template and an electronic mail list shall be considered to be sufficiently reproduced if the insurer can provide proof of mailing of the document and a copy of the template. Documents that require the signature of the insured or insurer's producer shall be maintained in any format listed above provided that evidence of the signature is preserved in that format.

b. The maintenance of records in a computer-based format shall be archival in nature, so as to preclude the alteration of the record after the initial transfer to a computer format. Upon request of an examiner, all records shall be capable of duplication to a hard copy that is as legible as the original document. The records shall be maintained according to written procedures developed and adhered to by the insurer. The written procedures shall be made available to the commissioner during an examination.

c. Photographs, microfilms, or other image-processing reproductions of records

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shall be equivalent to the originals and may be certified as the same in actions or proceedings before the commissioner unless inconsistent with the state administrative procedure act, chapter twenty-nine-a of the West Virginia Code.

4.8. Records required to be maintained by this rule shall be located as follows:

a. All records required to be maintained under this rule shall be kept in a location that will allow the records to be produced for examination within the time period required. When, under normal circumstances, someone other than the insurer maintains a required record or type of record, the other person's responsibility to maintain the records shall be set forth in a written agreement, a copy of which shall be maintained by the insurer and shall be available to the examiners for purposes of examination.

b. If required by law or otherwise available, the insurer shall maintain disaster preparedness or disaster recovery procedures that include provisions for the maintenance or reconstruction of original or duplicate records at another location. These procedures shall be provided for review during the examination.

4.9. Initial data requests will be submitted to a company at least thirty (30) days prior to the commencement of the on-site examination, desk audit or other form of review to provide ample time for the company to prepare the materials requested. Subdivisions a and b below apply to requests for supplemental data and information not anticipated at the time of the initial request.

a. As a means to facilitate the examination and to aid in the examination in accordance with W. Va. Code §33-2-9, an insurer shall provide any requested document or written response to an inquiry submitted by an examiner within five (5) working days, or such other time period as mutually agreed upon by the examiner and the insurer. It is a violation of this rule for an insurer to fail to produce a requested document within the specified time period unless the insurer can demonstrate to the satisfaction of the commissioner that the requested record cannot reasonably be provided within the specified time period of the request.

b. Additional records requested by the commissioner shall be made available for the examination upon the date specified by the examiner in charge.

4.10. Original records required to be provided during a market conduct examination will be returned to the insurer following the examination. If the records relate to an inquiry made by an examiner, copies of the records will become a part of the work papers of the examination. W. Va. Code §33-2-9 shall govern the public access to the work papers of the examination.

§114-15-5. Contracts for Services and Bond Requirements for Other Individuals.

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5.1. The commissioner may, as he or she considers necessary, retain any other individual or entity, as defined in subsection ~~2.11~~ 2.17 of this rule, to conduct, supervise, or participate in any examination, analysis or review as provided in W. Va. Code §33-2-9, or this rule.

5.2. Any contract between the commissioner and any other individual or entity, whose services are retained pursuant to this section, is specifically exempt from the competitive bidding requirements contained in W. Va. Code §5A-3-1 et seq.

5.3. The commissioner may, as he or she considers necessary, require any other individual or entity, whose services are retained pursuant to this section, to furnish an appropriate bond prior to conducting, supervising, or participating in any examination, analysis or review as provided in W. Va. Code §33-2-9 or this rule, as follows:

a. The bond shall be in an amount which in the commissioner's discretion is sufficient to complete the examination, analysis or review, but in no event shall be in an amount of less than ten thousand dollars (\$10,000.00).

b. Should the commissioner require any other individual or entity, whose services are retained pursuant to this section, to provide a bond, it shall be issued by a company licensed to transact surety insurance in the state of West Virginia as provided in W. Va. Code §33-19-1 and which has received at least an A rating by A.M. Best Company, Inc. in the year immediately preceding the date of the bond's issuance.

c. Proof of payment for and issuance of the bond shall be submitted to the commissioner prior to commencement of any examination, analysis or review by any other individual or entity whose services are retained pursuant to this section.

§114-15-6. Compensation and Accrued Time of Accredited Examiners.

6.1. ~~Salary~~--- Subject to the commissioner's approval, insurance company examiner supervisors and market conduct examiner supervisors shall receive the salary recommended for insurance examiners in-charge by the Financial Condition Examiners Handbook of the National Association of Insurance Commissioners. Subject to the commissioner's approval, insurance company examiners and market conduct examiners shall receive the salary recommended for insurance company examiners by the Financial Condition Examiners Handbook of the National Association of Insurance Commissioners.

6.2. An examiner's salary shall be calculated based upon a five-day work week.

6.3. ~~Accrued Time~~--- Examiners shall accrue and use annual leave and sick leave at the

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rates and in the manner established by current West Virginia Division of Personnel rules for state employees or by such other equivalent method as may be adopted by the state of West Virginia, and as supplemented by agency policies regarding use of annual and sick leave established by the commissioner.

a. On any West Virginia state or national holiday that a company being examined chooses to remain open and an examiner chooses to work, the examiner shall be properly compensated.

~~b. Annual leave may be taken by the examiner only upon written approval by the commissioner, deputy commissioner or chief examiner. The examiner must request approval at least as far in advance of the leave as the length of leave requested, i.e., for four (4) days leave, the request must be submitted at least four (4) days in advance. In a case of emergency, the requirement periods for advance request may be waived by the commissioner, deputy commissioner or chief examiner.~~

~~c. b. Examiners shall not be reimbursed for travel or living expenses for any day authorized as annual leave, except travel expenses may be reimbursed in connection with an authorized trip home as provided for in subsection 7.5 hereof.~~

~~d. On any day that the examiner is absent due to illness, the examiner shall telephone and inform the chief examiner directly of his or her planned absence before 9:30 a.m. on the day of the absence. In cases in which sick leave extends beyond three (3) working days, the reason for the absence shall be verified by a physician's statement. An examiner is subject to the appropriate disciplinary action for failure to comply with this subdivision.~~

~~e. c. Examiners shall continue to be reimbursed for living expenses during times of sick leave as long as the examiner remains at his or her on-site lodging during the illness.~~

§114-15-7. Travel and Living Expenses.

7.1. ~~Travel.~~--- Travel by examiners in connection with activities conducted pursuant to W. Va. Code §33-2-9 or this rule shall not be undertaken unless authorized by the commissioner ~~deputy commissioner or chief examiner~~ or his or her designee. Travel expenses ~~shall be~~ are subject to the following limitations:

a. All travel shall be by automobile unless otherwise authorized by the commissioner, ~~deputy commissioner or chief examiner~~ or his or her designee.

1. Examiners shall be compensated for the actual mileage traveled and other incidental expenses for in-state and out-of-state travel as allowed by the Governor's travel

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rules.

2. When an automobile is used, and the distance to an examination or to an assignment is four hundred (400) miles or more, the distance traveled per day shall not be less than four hundred (400) miles per day.

b. When air travel is authorized, a maximum of one (1) day's travel time is allowed and the examiner shall be reimbursed for actual travel expenses incurred.

c. Examiners may travel during regular working hours to and from the examination site no more frequently than every two weeks, and must be reimbursed for travel expenses associated with the travel: *Provided*, That if travel expenses do not exceed the expenses that the examiner would incur if he or she remained on-site, examiners may travel to and from their residences more frequently than every two weeks and must be reimbursed for travel expenses.

7.2. Living expenses will be reimbursed ~~as follows:~~ in accordance with the Governor's travel rules.

~~a. Lodging: The cost of the examiner's on-site lodging will be reimbursed at a rate equal to the actual cost of the lodging or \$100 per night, whichever is less, as verified by the lodging receipts attached to the request for reimbursement.~~

~~1. Examiners may be reimbursed for lodging expenses exceeding \$100 per night if they have obtained prior approval, in writing, from the chief examiner, deputy commissioner, or commissioner.~~

~~b. Meals and incidental expenses will be reimbursed at a per-diem rate equal to the rate then in effect for travel under the Governor's travel rules. Receipts are not required for reimbursement of meals and incidental expenses.~~

~~1. Meals and incidental expenses for single-day travel are not reimbursable. Single day travel is travel without an overnight stay.~~

~~2. When meals are provided for an examiner, the traveler's maximum per diem rate shall be reduced by an appropriate amount as set out in paragraph 4 of this subdivision.~~

~~3. Meals and incidental expenses not actually incurred shall not be reimbursed, and the maximum per diem rate will be reduced by the amounts set forth in paragraph 4 of this subdivision.~~

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~~4. The maximum per diem rate will be reduced as follows for each meal period which is not reimbursable:~~

~~A. Breakfast - 20% of the maximum per diem rate.~~

~~B. Lunch - 20% of the maximum per diem rate.~~

~~C. Dinner - 60% of the maximum per diem rate.~~

~~D. First day of travel - 20% of the maximum per diem rate.~~

~~c. a.~~ The street address of the examiner's on-site lodging shall be used in determining the per diem allowance.

~~d. b.~~ Weekend and holiday expenses: The examiner shall be reimbursed for lodging, meals and incidental expenses actually incurred on the basis of a seven-day week as long as the examiner actually occupies his or her on-site lodging on each day for which reimbursement is requested.

~~1. Examiners may be reimbursed for travel expenses incurred for their travel to their domiciles or residences on weekends and holidays if the expenses do not exceed the expenses the examiner would have incurred if he or she stayed on-site.~~

~~e. c.~~ The commissioner may not authorize living expenses if the examination takes place in a location within fifty (50) miles (one way) of an examiner's residence. However, the examiner will be compensated for actual mileage traveled and other incidental expenses as allowed by the Governor's travel rules.

~~f. d.~~ Examiners and other employees may, with the approval of the commissioner or ~~deputy commissioner~~ his or her designee, be compensated for travel and living expenses in accordance with the Governor's travel rules when attending training, educational courses, conferences, seminars or other activities authorized by the commissioner. Registration fees may be included as expenses that can be reimbursed to the examiners or other employees.

~~7.3. Examiners may, with the commissioner's approval, be reimbursed for examination fees incurred as a consequence of examination for designation as a certified financial examiner, or certified insurance examiner, provided that a passing score is achieved on the examination. Other expenses incurred in connection with the examination, including travel, lodging and meals, may not be reimbursed.~~

~~7.4. 7.3.~~ Other individuals or entities involved in activities conducted pursuant to W. Va.

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Code §33-2-9 or this rule who are billing directly as authorized in subsection ~~4.1~~ 3.4 of this rule shall file a schedule of their fees and charges with the commissioner prior to incurring any charges. These individuals or entities shall submit copies of their billings to the commissioner simultaneously with their submission to the billed entity, individual or person.

~~7.5. The commissioner may authorize trips home for an examiner to return to his or her domicile twenty-four (24) times in any one fiscal year. Provided, however, that the commissioner may not authorize an examiner to return to his or her place of residence more than eight (8) times in any one quarterly period. The examiner will be reimbursed the lesser of air fare or mileage in lieu of living expenses. An examiner shall utilize his or her accrued leave time for the travel. Travel will be done with a minimum amount of work time lost. For purposes of this subsection of this rule, "domicile" refers to an examiner's place of legal residence as on file with the Insurance Commissioner. An examiner shall immediately inform the department of any change in legal residence.~~

~~a. Travel requests for authorized trips home must be submitted and approved at least twenty (20) days in advance. All airline travel arrangements must be made through the commissioner's Director of Administration.~~

§114-15-8. Examiner Reporting Requirements.

8.1. ~~Each examiner~~ The examiner in charge shall prepare an "examiner's semimonthly days worked report" to be submitted on a form prescribed by the commissioner. The form shall be submitted to the commissioner within three (3) days of the end of each semimonthly pay period. The report shall contain the following information:

- a. The period of time the report covers;
- b. The name of entity, individual or person that the examiner has been examining is being examined and their normal hours of operation;
- c. The mailing address and street address, including county, of the business location of the entity being examined, and the mailing address and street address of the examiner's on-site lodging;
- d. The telephone number(s) and extension(s) where the examiner can be reached at all times;
- e. The domiciliary state, if the examination is being performed on a non-domestic entity;

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~~f. The Examiner In Charge or Insurance Company Examiner Supervisor, if other than the reporting examiner;~~

~~g. f. A listing of any other examiners individual or entity participating in the assignment and their domicile or zone representation, if applicable;~~

~~h. g. A description of the phases of the examination or assignment that the examiner worked on during the reporting period;~~

~~i. h. Comments on any unusual or controversial items;~~

~~j. i. The tentative closing date of the assignment;~~

~~k. j. A schedule of each of the days in the reporting period and the examiner's status on that day, to include the following work status categories: the total of days designated as work days, annual days, sick days and expense days; and~~

~~1. Work day, annual day, sick day, expense day;~~

~~2. Each category shall be totaled at the bottom of the schedule;~~

and

~~l. k. The examiner's name and signature of the examiner in charge completing the report and a statement that the information provided is true and correct. and~~

~~m. The name and signature of the Chief Examiner, Insurance Company Examiner Supervisor, or Examiner In Charge, if other than the reporting examiner, verifying the information.~~

8.2. The information identified in subsection 8.1 of this ~~rule~~ section is necessary to satisfy the substantiation of business expenses requirement of the Internal Revenue Service placed upon the ~~Insurance Commissioner~~ commissioner as an employer. Failure on the part of the examiner to provide any of the information could require the offices of the insurance commissioner of West Virginia to report expense amounts as income of the examiner to the Internal Revenue Service.

8.3. An examiner shall report changes to his or her telephone number and extension to the commissioner between reporting periods. Failure to report the changes could affect the commissioner's ability to consider an examiner's business expenses as substantiated.