WEST VIRGINIA CODE CHAPTER 33 ARTICLE 16A

WV Legislature

§33-16A-1. Right of insured to convert from group coverage.

A group policy or group subscriber contract which provides hospital, surgical or major medical expense insurance, or any combination of these coverages, on an expense incurred basis, but not a policy which provides benefits for specific diseases or for accidental injuries only, shall provide that an employee or member whose insurance under the group policy or contract has been terminated for any reason, including discontinuance of the group policy in its entirety or of an insured class, who has been continuously insured under the group policy, or under any group policy providing similar benefits which it replaces, for at least three months immediately prior to termination, shall be entitled to have issued to him by the insurer a converted policy of health insurance. An employee or member shall not be entitled to have a converted policy issued to him if termination of his insurance under the group policy occurred because he failed to pay any required contribution, or the discontinued group coverage was replaced by similar group coverage within thirty-one days.

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§33-16A-2. Issuance of converted policy.

Issuance of a converted policy shall be subject to the following conditions:

(a) Written application for the converted policy shall be made and the first premium paid to the insurer not later than thirty-one days after termination of the group policy or contract.

(b) The converted policy shall be issued without evidence of insurability.

(c) The initial premium for the converted policy for the first twelve months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to individually underwritten standard risks, to the age and class of risk of each person to be covered under the converted policy and to the type and amount of insurance provided. The experience under converted policies shall not be an acceptable basis for establishing rates for converted policies.

If an insurer experiences or incurs losses for a period of two years on conversion policies which exceed earned premiums by more than twenty percent, the insurer may file with the commissioner amended renewal rates for the subsequent year, which will produce a loss ratio of not less than one hundred twenty percent.

Conditions pertaining to health shall not be an acceptable basis for classification for the purposes of this section. The frequency of premium payment shall be the frequency customarily required by the insurer for the policy form and plan selected: Provided, That the insurer shall not require premium payments less frequently than quarterly.

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§33-16A-3. Effective date of policy.

The effective date of the converted policy shall be the day following the termination of insurance under the group policy.

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§33-16A-4. Coverage of dependents.

The converted policy shall cover the employee or member and his dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

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§33-16A-5. Persons for whom coverage not required.

The insurer shall not be required to issue a converted policy covering any person if such person is or could be covered by Medicare (Title XVIII of the United State Social Security Act as supplemented by the Social Security Amendments of 1965 or as later amended or superseded). Furthermore, the insurer shall not be required to issue a converted policy covering any person if:

(a) (1) Such person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program; or

(2) Similar benefits are provided to such person, pursuant to or in accordance with the requirements of any state or federal law; and

(b) The benefits provided under the sources referred to in (1) above for such person or benefits provided under the sources referred to in (2) above for such person, together with the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards. The insurer's standards must bear some reasonable relationship to actual health care costs in the area in which the insured lives at the time of conversion and must be filed with the commissioner prior to their use in denying coverage.

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§33-16A-6. Inquiries by insurer.

A converted policy may include a provision whereby the insurer may request information in advance of any premium due date of such policy of any person covered thereunder as to whether (i) he is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program, (ii) he is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or (iii) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law. The converted policy may provide that the insurer may refuse to renew the policy or the coverage of any person insured thereunder for the following reasons only:

(a) Either the benefits provided under the sources referred to in (i) and (ii) above for such person or benefits provided or available under the sources referred to in (iii) above for such person, together with the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards on file with the commissioner or the converted policyholder fails to provide the requested information;

(b) Fraud or material misrepresentation in applying for any benefits under the converted policy;

(c) Eligibility of the insured person for coverage under Medicare (Title XVIII of the United States Social Security Act as supplemented by the Social Security Amendments of 1965 or as later amended or superseded) or under any other state or federal law providing for benefits similar to those provided by the converted policy;

(d) Other reasons approved by the commissioner.

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§33-16A-7. Limits of coverage.

An insurer shall not be required to issue a converted policy which provides benefits in excess of those provided under the group policy from which conversion is made.

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§33-16A-8. Preexisting conditions; reduction of benefits.

The converted policy shall not exclude a preexisting condition not excluded by the group policy. However, the converted policy may provide that any hospital, surgical or medical benefits payable thereunder may be reduced by the amount of any such benefits payable under the group policy after the termination of the individual's insurance thereunder. The converted policy may also include provisions so that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force and effect.

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§33-16A-9. Alternate plans of conversion coverage.

If the group insurance policy from which conversion is made insures the employee or member for basic hospital or surgical expense insurance, the employee or member shall be entitled to obtain a converted policy providing, at his option, coverage on an expense incurred basis under any one of the plans meeting the following requirements:

Plan A

(a) Hospital room and board daily expense benefits in a maximum dollar amount approximating the average semiprivate rate charged in metropolitan areas of this state, for a maximum duration of seventy days;

(b) Miscellaneous hospital expense benefits of a maximum amount of ten times the hospital room and board daily expense benefits; and

(c) Surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of $800; or

Plan B

(a) Hospital room and board daily expense benefits in a maximum dollar amount equal to seventy-five percent of the maximum dollar amount determined for Plan A, for a maximum duration of seventy days;

(b) Miscellaneous hospital expense benefits of a maximum amount of ten times the hospital room and board daily expense benefits; and

(c) Surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of $600; or

Plan C

(a) Hospital room and board daily expense benefits in a maximum dollar amount equal to fifty percent of the maximum dollar amount determined for Plan A, for a maximum duration of seventy days;

(b) Miscellaneous hospital benefits of a maximum amount of ten times the hospital room and board daily expense benefits; and

(c) Surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of $400.

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The maximum dollar amounts in Plan A shall be determined by the commissioner and may be redetermined by him from time to time as to converted policies issued subsequent to such redetermination. Such redetermination shall not be made more often than once in three years. The maximum dollar amounts in Plans A, B and C shall be rounded to the nearest multiple of $10.

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§33-16A-10. Additional coverage.

If the group insurance policy from which conversion is made insures the employee or member for major medical expense insurance, the employee or member shall be entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:

(a) A maximum benefit at least equal to either, at the option of the insurer, (1) or (2) below:

(1) The smaller of the following amounts:

(A) The maximum benefit provided under the group policy.

(B) A maximum payment of $250,00 per covered person for all covered medical expenses incurred during the covered person's lifetime.

(2) The smaller of the following amounts:

(A) The maximum benefit provided under the group policy.

(B) A maximum payment of $250,000 for each unrelated injury or sickness.

(b) Payment of benefits at the rate of eighty percent of covered medical expenses which are in excess of the deductible, until twenty percent of such expenses in a benefit period reaches $1,000, after which benefits will be paid at the rate of one hundred percent during the remainder of such benefit period. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than fifty percent.

(c) A deductible for each benefit period which, at the option of the insurer, shall be (1) the sum of the benefits deductible and $100, or (2) the corresponding deductible in the group policy. The term "benefits deductible," as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other hospital, surgical, or medical insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis, or in accordance with the requirements of any state or federal law and, if pursuant to section eleven of this article, the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits.

If the maximum benefit is determined by (a) (2) above, the insurer may require that the deductible be satisfied during a period of not less than three months if the deductible is $100 or less, and not less than six months if the deductible exceeds $100.

(d) The benefit period shall be each calendar year when the maximum benefit is determined by (a) (1) above or twenty-four months when the maximum benefit is determined by (a) (2)

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above.

(e) The term "covered medical expenses," as used above, shall include at least, in the case of hospital room and board charges, the lesser of the dollar amount in Plan A and the average semiprivate room and board rate for the hospital in which the individual is confined and twice such amount for charges in an intensive care unit. Any surgical schedule shall be consistent with those customarily offered by the insurer under group or individual health insurance policies and must provide at least a $1,200 maximum benefit.

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§33-16A-10a. Continuum of care services.

If the group insurance policy from which conversion is made insures the employee or member for continuum of care services pursuant to article five-d, chapter sixteen of this code, the employee or member shall be entitled to obtain a converted policy providing benefits for continuum of care services to the same extent such benefits are provided in the group insurance policy: Provided, That any insurance carrier required to provide supplemental insurance coverage for continuum of care services hereunder shall not be required to expend funds for underwriting such supplemental coverage until the continuum of care board, in cooperation with the West Virginia state Insurance Commissioner, shall have completed a written master plan related to insurance coverage as set forth in section five, article five-d, chapter sixteen of the Code of West Virginia, 1931, as amended, including, but not limited to, the specific standards and coverages to be provided in such supplemental coverage: Provided, however, That a public hearing shall be held pursuant to the provisions of chapter twenty-nine-a of this code applicable to such proceedings prior to the considerations of the aforesaid plan by said board. The rates for continuum of care coverage shall accurately reflect the cost of such coverage and shall not be subsidized by the rate structure for any other coverage.

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§33-16A-11. Combined policy coverage.

The conversion privilege required by this article shall, if the group insurance policy insures the employee or member for basic hospital or surgical expense insurance as well as major medical expense insurance, make available the plans of benefits set forth in sections nine and ten of this article. At the option of the insurer, such plans or benefits may be provided under one policy.

The insurer may also, in lieu of the plans of benefits set forth in sections nine and ten of this article, provide a policy of comprehensive medical expense benefits without first dollar coverage. Said policy shall conform to the requirements of section ten of this article: Provided, That an insurer electing to provide such a policy shall make available a low deductible option, not to exceed $100, a high deductible option between 500 and $1,000, and a third deductible option midway between the high and low deductible options.

The insurer may, at its option, also offer alternative plans for group health conversion in addition to those required by this article.

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§33-16A-12. Coverage following retirement.

In the event coverage would be continued under the group policy on an employee following his retirement, but prior to the time he is or could be covered by Medicare, he may elect, in lieu of such continuation of group insurance, to have the same conversion rights as would apply had his insurance terminated at retirement by reason of termination of employment or membership.

The converted policy may provide for reduction of coverage on any person upon his eligibility for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy.

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§33-16A-13. Other conversion privileges.

Subject to the conditions set forth in the previous sections of this article, the conversion privilege shall also be available (a) to the surviving spouse, if any, at the death of the employee or member, with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death, otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or, if the group policy provides for continuation of dependents coverage following the employee's or member's death, at the end of such continuation, (b) to the spouse of the employee or member upon termination of coverage of the spouse, while the employee or member remains insured under the group policy, by reason of ceasing to be a qualified family member under the group policy, with respect to the spouse and such children whose coverage under the group policy terminates at the same time, or (c) to a child solely with respect to himself upon termination of his coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.

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§33-16A-14. Benefit levels; election to provide group coverage; notification of conversion privilege; policy delivered outside state.

(a) If the benefit levels required in section nine of this article exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy in lieu of those required in section nine.

(b) The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual policy.

(c) The insurer, prior to terminating the policy for any reason, shall notify each employee or member, or such employee's or member's spouse, child or dependent entitled to the conversion privilege under this article, at least sixty days in advance of the termination, in writing, of the pending termination. The notice shall inform the employee or member of the conversion privilege provided in this article.

(d) A notification of the conversion privilege shall also be included in each certificate of coverage.

(e) A converted policy which is delivered outside this state must be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

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§33-16A-15. Child immunization services coverage.

All policies issued pursuant to this article shall cover the cost of child immunization services as described in section five, article three, chapter sixteen of this code, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration. These services shall be exempt from any deductible, per-visit charge and/or copayment provisions which may be in force in these policies or contracts. This section does not require that other health care services provided at the time of immunization be exempt from any deductible and/or copayment provisions.

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