WEST VIRGINIA CODE CHAPTER 33 ARTICLE 28

§33-28-1. Short title.

This article shall be known and cited as the "West Virginia Individual Accident and Sickness Insurance Minimum Standards Act."

§33-28-2. Purpose of article.

The purpose of this article is to provide reasonable standardization and simplification of terms and coverages of individual accident and sickness insurance policies and subscriber contracts of hospital and medical service corporations in order to facilitate public understanding and comparison and to eliminate provisions contained in individual accident and sickness insurance policies and subscriber contracts of hospital and medical service corporations which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims and to provide for full disclosure in the sale of such coverages.

§33-28-3. Definition of terms used in article.

As used in this article, unless used in a context that clearly requires a different meaning, the term:

(a) "Form" means a policy, contract, rider, endorsement or application as provided in section eight, article six of this chapter when used to describe an individual accident and sickness policy form, and means a contract, application, rider or endorsement as provided in section six, article twenty-four of this chapter when used to describe a hospital or medical service corporation subscriber's contract.

(b) "Accident and sickness insurance" means insurance written under article fifteen of this chapter, other than credit accident and sickness insurance, and coverages written under article twenty-four of this chapter. For purposes of this article, hospital, medical and dental service corporations shall be deemed to be engaged in the business of insurance.

(c) "Policy" means the entire contract between an insurer and an individual insured, including the policy, riders, endorsements and the application, if attached. The term "policy" shall not include coverages issued pursuant to a conversion privilege under a policy or contract of group insurance.

(d) "Subscriber contract" means the entire subscriber contract issued by a hospital, medical or dental service corporation to an individual subscriber, including the contract, riders, endorsements and the application, if attached. The term "subscriber contract" shall not include coverages issued pursuant to a conversion privilege under a policy or contract of group insurance.

(e) "Direct response insurance product" means an individual policy of accident and sickness insurance or a subscriber contract of a hospital, medical or dental service corporation, the sale of which is effected through direct contact between an insurer and an individual insured or between a hospital, medical or dental service corporation and a subscriber, without employing the intermediary services of an agent, broker or solicitor.

§33-28-4. Standards for policy provisions.

(a) The commissioner shall promulgate rules and regulations, in accordance with chapter twenty-nine-a of the code, to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content and required disclosure for the sale of individual policies of accident and sickness insurance and subscriber contracts of hospital, medical and dental service corporations which shall be in addition to, and in accordance with, applicable laws of this state. Such rules and regulations may cover, but shall not be limited to:

(1) Terms of renewability;

(2) Initial and subsequent conditions of eligibility;

(3) Nonduplication of coverage provisions;

(4) Coverage of dependents;

(5) Preexisting conditions;

(6) Termination of insurance;

(7) Probationary periods;

(8) Limitations;

(9) Exceptions;

(10) Reductions;

(11) Elimination periods;

(12) Requirements for replacement;

(13) Recurrent conditions; and

(14) The definition of terms including, but not limited to, hospital, accident, sickness, injury, physician, accidental means, total disability, permanent disability, partial disability, nervous disorder, guaranteed renewable and noncancelable.

(b) The commissioner may promulgate rules and regulations, in accordance with chapter twenty-nine-a of the code, specifying prohibited provisions of policies and subscriber contracts not otherwise specifically authorized by statute which in the opinion of the commissioner are unjust, unfair or unfairly discriminatory either to the policyholder, subscriber, beneficiary or any person insured under the policy.

§33-28-5. Minimum standards for benefits.

(a) The commissioner shall promulgate rules and regulations, in accordance with chapter twenty-nine-a of the code, to establish minimum standards for benefits under each of the following categories of coverage in individual policies of accident and sickness insurance and subscriber contracts of hospital, medical, dental and service corporations:

(1) Basic hospital expense coverage;

(2) Basic medical-surgical expense coverage;

(3) Hospital confinement indemnity coverage;

(4) Major medical expense coverage;

(5) Disability income protection coverage;

(6) Accident only coverage; and

(7) Specified disease or specified accident coverage.

(b) Nothing in this section shall preclude the issuance of any policy or subscriber contract which combines two or more of the categories of coverage enumerated in subdivisions (1) through (6) of subsection (a) of this section.

(c) No policy or subscriber contract shall be delivered or issued for delivery in this state which does not meet the prescribed minimum standards for the categories of coverage listed in subdivisions (1) through (7) of subsection (a) of this section unless the commissioner finds that such policy or subscriber contract will be in the public interest and that such policy or subscriber contract contains benefits which are reasonable in relation to the premium charged.

(d) The commissioner shall prescribe the method of identification of policies and subscriber contracts based upon coverages provided.

§33-28-5a. Home health care coverage.

(a) Any insurer who, on or after January 1, 1981, delivers or issues for delivery in this state individual basic hospital expense or major medical expense coverage shall make available to the policyholder home health care coverage consistent with the provisions of this section. For purposes of this section, "home health care" means health services provided by a home health agency certified in the state in which the home health services are delivered or under Title XVIII of the Social Security Act.

(b) Home health care coverage offered shall include:

(1) Services provided by a registered nurse or a licensed practical nurse;

(2) Health services provided by physical, occupational, respiratory and speech therapists;

(3) Health services provided by a home health aide to the extent that such services would be covered if provided to the insured on an inpatient basis;

(4) Medical supplies, drugs, medicines and laboratory services to the extent that they would be covered if provided to the insured on an inpatient basis; and

(5) Services provided by a licensed midwife or a licensed nurse midwife as these occupations are defined in section one, article fifteen of the code.

(c) Home health care coverage may be limited to:

(1) Services provided on the written order of a licensed physician, provided such order is renewed at least every sixty days;

(2) Services provided, directly or through contractual agreements, by a home health agency certified in the state in which the home health services are delivered or under Title XVIII of the Social Security Act; and

(3) Services as set forth in subsection (b) of this section without which the insured would have to be hospitalized.

(d) Coverage under this section shall be provided for at least one hundred home visits per insured per policy year, with each home visit by a member of a home health care team to be considered as one home health care visit including up to four hours of home health care services.

(e) No such policy need provide such coverage to persons eligible for Medicare.

§33-28-5b. Medicare supplement insurance.

(a) Definitions. --

(1) "Applicant" means, in the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits.

(2) "Medicare supplement policy" means an individual policy of accident and sickness insurance or a subscriber contract (of hospital and medical service corporations or health maintenance organizations), other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.), or an issued policy under a demonstration project specified in 42 U.S.C. §1395ss(g)1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. Such term does not include:

(A) A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations; or

(B) A policy or contract of any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association is composed of individuals all of whom are actively engaged in the same profession, trade or occupation; has been maintained in good faith for purposes other than obtaining insurance; and has been in existence for at least two years prior to the date of its initial offering of such policy or plan to its members; or

(C) Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this section.

(3) "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(b) Standards for policy provisions. --

(1) The commissioner shall issue reasonable rules to establish specific standards for policy provisions of Medicare supplement policies. Such standards shall be in addition to and in accordance with the applicable laws of this state and may cover, but shall not be limited to:

(A) Terms of renewability;

(B) Initial and subsequent conditions of eligibility;

(C) Nonduplication of coverage;

(D) Probationary period;

(E) Benefit limitations, exceptions and reductions;

(F) Elimination period;

(G) Requirements for replacement;

(H) Recurrent conditions; and

(I) Definitions of terms.

(2) The commissioner may issue reasonable rules that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair or unfairly discriminatory to any person insured or proposed for coverage under a Medicare supplement policy.

(3) Notwithstanding any other provisions of the law, a Medicare supplement policy may not deny a claim for losses incurred more than six months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(c) Minimum standards for benefits. -- The commissioner shall issue reasonable rules to establish minimum standards for benefits under Medicare supplement policies.

(d) Loss ratio standards. -- Medicare supplement policies shall be expected to return to policyholders benefits which are reasonable in relation to the premium charge. The commissioner shall issue reasonable rules to establish minimum standards for loss ratios for Medicare supplement policies on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed to provide coverage and in accordance with accepted actuarial principles and practices. For purposes of rules issued pursuant to this subsection, Medicare supplement policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

(e) Disclosure standards. --

(1) In order to provide for full and fair disclosure in the sale of accident and sickness policies, to persons eligible for Medicare, the commissioner may require by rule that no policy of accident and sickness insurance may be issued for delivery in this state and no certificate may be delivered pursuant to such a policy unless an outline of coverage is delivered to the applicant at the time application is made.

(2) The commissioner shall prescribe the format and content of the outline of coverage required by subdivision (1) of this subsection. For purposes of this subdivision, "format"

means style, arrangements and overall appearance, including such items as size, color and prominence of type and the arrangement of text and captions. Such outline of coverage shall include:

(A) A description of the principal benefits and coverage provided in the policy;

(B) A statement of the exceptions, reductions and limitations contained in the policy;

(C) A statement of the renewal provisions including any reservation by the insurer of the right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age;

(D) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(3) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for Medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the information brochure be provided to any prospective insureds eligible for Medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

(4) The commissioner may further promulgate reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts or certificates by persons eligible for Medicare.

(f) Notice of free examination. -- Medicare supplement policies or certificates, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days from its delivery and have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner. Medicare supplement policies or certificates issued pursuant to a direct response solicitation to persons eligible for Medicare shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

(g) Administrative procedures. -- Rules promulgated pursuant to this section shall be subject to the provisions of chapter twenty-nine-a (the West Virginia Administrative Procedures Act)

of this code.

(h) Severability. -- If any provision of this section or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the section and the application of such provision to other persons or circumstances shall not be affected thereby.

§33-28-6. Outline of coverage.

(a) In order to provide for full and fair disclosure in the sale of individual accident and sickness insurance policies or subscriber contracts of hospital, medical and dental service corporations, no such policy or subscriber contract shall be delivered or issued for delivery in this state unless:

(1) In the case of a direct response insurance product, the outline of coverage described in subsection (b) of this section accompanies the policy or subscriber contract; and

(2) In all other cases, the outline of coverage described in subsection (b) of this section is delivered to the applicant at the time application is made and an acknowledgment of receipt or certificate of delivery of such outline is provided the insurer or hospital, medical or dental service corporation with the application. In the event the policy or subscriber contract is issued on a basis other than that applied for, the outline of coverage properly describing the policy or subscriber contract must accompany the policy or subscriber contract when it is delivered and clearly state that it is not the policy or subscriber contract for which application was made.

(b) The commissioner shall, by promulgation of appropriate rules and regulations in accordance with chapter twenty-nine-a of the code, prescribe the format and content of the outline of coverage required by subsection (a) of this section. "Format" means style, arrangement and overall appearance, including such items as the size, color and prominence of type and the arrangement of text and captions. Such outline of coverage shall include:

(1) A statement identifying the applicable category or categories of coverage provided by the policy or subscriber contract as prescribed in section five of this article;

(2) A description of the principal benefits and coverage provided in the policy or subscriber contract;

(3) A statement of the exceptions, reductions and limitations contained in the policy or subscriber contract;

(4) A statement of the renewal provisions, including any reservation by the insurer or hospital, medical or dental service corporation of a right to change premiums; and

(5) A statement that the outline of coverage is a summary of the policy or subscriber contract issued or applied for and that the terms of the policy or subscriber contract should be consulted to determine governing contractual provisions.

§33-28-7. Preexisting conditions.

Notwithstanding the provisions of section four, article fifteen of this chapter if an insurer or a hospital, medical or dental service corporation elects to use a simplified application form containing no questions concerning the applicant's health history or medical treatment history, the policy or contract applied for must cover any loss occurring after twelve months from the inception date of coverage which loss is traceable to a preexisting condition not specifically excluded from coverage by the terms of the policy, and, except as so provided, the policy or contract shall not include wording which would permit a defense based upon preexisting conditions.