APPROVED AND SIGNED BY THE GOVERNOR

Date 4-28-81

Time

No. 269

WEST VIRGINIA LEGISLATURE

REGULAR SESSION, 1981

ENROLLED

Committee Substitute for

SENATE BILL NO. 269

(By Mr. Nelson & Mr. Harman)

PASSED April 11, 1981

In Effect ninety days from Passage

ENROLLED

COMMITTEE SUBSTITUTE

FOR

Senate Bill No. 269

(MR. NELSON and MR. HARMAN, *original sponsors*)

[Passed April 11, 1981; in effect ninety days from passage.]

AN ACT to amend article sixteen, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, by adding thereto two new sections, designated sections three-c and three-d; to amend and reenact section four, article twenty-four of said chapter thirty-three; and to amend article twenty-eight of said chapter thirty-three by adding thereto a new section, designated section five-b; all relating to provisions required in policies of group accident and sickness; coverage for alcoholic treatment; medical supplement insurance; hospital, medical and dental service corporations; minimum policy standards.

Be it enacted by the Legislature of West Virginia:

That article sixteen, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended by adding thereto two new sections, designated sections three-c and three-d; that section four, article twenty-four of said chapter thirty-three be amended and reenacted; and that article twenty-eight of said chapter thirty-three be amended by adding thereto a new section, designated section five-b, all to read as follows:

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3c. Coverage for alcoholic treatment.

No group, blanket, franchise or association accident and sickness insurance policy providing coverage on an expense incurred basis, nor group, blanket, franchise or association service or indemnity type contract issued by a service corporation pursuant to the provisions of section one, article twenty-four, chapter thirty-three of this code shall be issued, delivered, executed or renewed in this state unless such policy or contract, at the option of the policyholder or sponsor, provides the level of benefits specified herein to any insured, subscriber or other person covered under the policy or contract for expenses incurred in connection with the treatment of alcoholism, when such treatment is prescribed by a duly licensed physician, subject to the right of the policyholder or sponsor to select any alternative level of benefits as may be offered by the insurer or service corporation. For purposes of this section, alcoholism is hereby defined as a chronic disorder or illness in which the individual is unable, for psychological or physical reasons, or both, to refrain from the frequent consumption of alcohol in quantities sufficient to produce intoxication and, ultimately, injury to health and effective functioning. Benefits provided under this section shall include a minimum of thirty days of inpatient confinement as defined in the policy of contract. If inpatient hospital benefits are provided beyond thirty days of confinement, the durational limits, dollar limits, deductibles and co-insurance factors applicable thereto need not be the same as applicable to physical illness generally. As to outpatient benefits, the co-insurance factor may not exceed fifty percent of the co-insurance factor applicable for physical illness generally, whichever is greater, and the maximum benefit for alcoholism in the aggregate during any applicable benefit period may be limited to not less than seven hundred fifty dollars. Maximum lifetime benefits may, as to alcoholism in the aggregate, be no less than an amount equal to the lesser of ten thousand dollars or twenty-five percent of the lifetime policy limit. "Inpatient hospital benefits" means only those payable for charges made by a hospital, as defined in the policy or contract, for the necessary care and treatment of alcoholism furnished to a covered person while confined as a hospital inpatient; and with respect to major medical

policies or contracts, also those payable for charges made by a physician, as defined in the policy or contract, for the necessary care and treatment of alcoholism furnished to a covered person while confined as a hospital inpatient. "Outpatient benefits" means only those payable for (1) charges made by a hospital for the necessary care and treatment of alcoholism furnished to a covered person while not confined as a hospital inpatient, (2) charges for services rendered or prescribed by a physician for the necessary care and treatment for alcoholism furnished to a covered person while not confined as a hospital inpatient, and, (3) charges made by an alcoholism treatment center, as defined herein, for the necessary care and treatment of a covered person provided in such treatment center. "Alcoholism Treatment Center" means a treatment facility which provides a program for the treatment of alcoholism pursuant to a written treatment plan approved and monitored by a physician, and which facility is also: (1) affiliated with a hospital under a contractual agreement with an established system for patient referral, or (2) licensed, certified or approved as an alcoholism treatment center by the state. This section shall not apply to blanket, short-term travel, accident only, limited or specified disease, individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as medicare, or any other similar coverage under state or federal governmental plan.

§33-16-3d. Medicare supplement insurance.

(a) Definitions.

(1) "Applicant" means in the case of a group medicare supplement policy or subscriber contract the proposed certificateholder.

(2) "Certificate" means, for the purposes of this section, any certificate issued under a group medicare supplement policy, which policy has been delivered or issued for delivery in this state.

(3) "Medicare Supplement Policy" means a group policy of accident and sickness insurance or a subscriber contract (of hospital and medical service associations) 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 by reason of age. 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.

(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.

(4) "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 regulations 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 regulations 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 regulations 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 regulations to establish minimum standards for loss ratios and 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 regulations issued pursuant to this paragraph, 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 by reason of age, the commissioner may require by regulation 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 paragraph one. For purposes of this paragraph, "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;

(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 regulation a standard form and the contents of an informational brochure for persons eligible for medicare by reasons of age, 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 regulation 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 regulation that the prescribed brochure be provided upon request to any prospective insureds eligible for medicare by reason of age, but in no event later than the time of policy delivery.

(4) The commissioner may further promulgate reasonable regulations 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 by reason of age.

(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 of certificate within ten 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. Medicare supplement policies or certificates issued pursuant to a direct

response solicitation to persons eligible for medicare by reason of age 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.

(g) Administrative procedures.

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

(h) Separability.

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.

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS AND DENTAL SERVICE CORPORATIONS.

§33-24-4. Exemptions; applicability of other laws.

Every such corporation is hereby declared to be a scientific, nonprofit institution and as such exempt from the payment of all property and other taxes. Every such corporation, to the same extent such provisions are applicable to insurers transacting similar kinds of insurance and not inconsistent with the provisions of this article, shall be governed by and be subject to the provisions, as hereinbelow indicated, of the following articles of this chapter: Article two (insurance commissioner) except that under section nine of article two examinations shall be conducted at least once every four years, article four (general provisions) except that section sixteen of article four shall not be applicable thereto, article ten (rehabilitation and liquidation), article eleven (unfair practices and frauds), article twelve (agents, brokers and solicitors) except that the agent's license fee shall be one dollar, section three-c, article sixteen (group accident and sickness insurance), section three-d, article sixteen (medicare supplement), and article twenty-eight (individual accident and sickness insurance minimum standards); and no other provision of this chapter shall apply to such corporations unless specifically made applicable by the provisions of this

article. If, however, any such corporation shall be converted into a corporation organized for a pecuniary profit, or if it shall transact business without having obtained a license as required by section five of this article, it shall thereupon forfeit its right to these exemptions.

ARTICLE 28. INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS.

§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 associations) 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 by reason of age. 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.

(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 regulations 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 regulations 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 regulations 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 regulations to establish minimum standards for loss ratios and 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 regulations issued pursuant to this paragraph, 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 by reason of age, the commissioner may require by regulation 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 paragraph one. For purposes of this paragraph, "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;

(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 regulation a standard form and the contents of an informational brochure for persons eligible for medicare by reasons of age, 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 regulation 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 regulation that the prescribed brochure be provided upon request to any prospective insureds eligible for medicare by

reason of age, but in no event later than the time of policy delivery.

(4) The commissioner may further promulgate reasonable regulations 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 by reason of age.

(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 of certificate within ten 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. Medicare supplement policies or certificates issued pursuant to a direct response solicitation to persons eligible for medicare by reason of age 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.

(g) Administrative procedures.

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

(h) Separability.

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.

The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

R. P. Baylor
Chairman Senate Committee

Tony E. Whitlow
Chairman House Committee

Originated in the Senate.

To take effect ninety days from passage.

Todd C. Wells
Clerk of the Senate

C. A. Blankenship
Clerk of the House of Delegates

President of the Senate

Hyde M. Lee, Jr.
Speaker House of Delegates

The within is approved this the 22

day of April 1981.

John D. Rockefeller IV
Governor