

APPROVED AND SIGNED BY THE GOVERNOR

Date 4-28-81

Time \_\_\_\_\_

770: 269

WEST VIRGINIA LEGISLATURE  
REGULAR SESSION, 1981



**ENROLLED**

*Committee Substitute for*  
SENATE BILL NO. 269

(By Mr. Alison & Mr. Harmon)



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.**

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

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

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

1 (a) Definitions.

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

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

9 (3) "Medicare Supplement Policy" means a group policy  
 10 of accident and sickness insurance or a subscriber contract  
 11 (of hospital and medical service associations) which is  
 12 advertised, marketed or designed primarily as a supplement  
 13 to reimbursements under medicare for the hospital, medical

14 or surgical expenses of persons eligible for medicare by  
15 reason of age. Such term does not include:

16 (A) A policy or contract of one or more employers or labor  
17 organizations, or of the trustees of a fund established by one  
18 or more employers or labor organizations, or a combination  
19 thereof, for employees or former employees, or combination  
20 thereof, or for members or former members, or combination  
21 thereof, of the labor organizations, or

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

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

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

39 (b) Standards for policy provisions.

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

45 (A) Terms of renewability;

46 (B) Initial and subsequent conditions of eligibility;

47 (C) Nonduplication of coverage;

48 (D) Probationary period;

49 (E) Benefit limitations, exceptions and reductions;

50 (F) Elimination period;

51 (G) Requirements for replacement;

52 (H) Recurrent conditions; and

53 (I) Definitions of terms.

54 (2) The commissioner may issue reasonable regulations  
55 that specify prohibited policy provisions not otherwise

56 specifically authorized by statute which, in the opinion of the  
57 commissioner, are unjust, unfair or unfairly discriminatory to  
58 any person insured or proposed for coverage under a  
59 medicare supplement policy.

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

68 (c) Minimum standards for benefits.

69 The commissioner shall issue reasonable regulations to  
70 establish minimum standards for benefits under medicare  
71 supplement policies.

72 (d) Loss ratio standards.

73 Medicare supplement policies shall be expected to return to  
74 policyholders benefits which are reasonable in relation to the  
75 premium charge. The commissioner shall issue reasonable  
76 regulations to establish minimum standards for loss ratios  
77 and medicare supplement policies on the basis of incurred  
78 claims experience and earned premiums for the entire period  
79 for which rates are computed to provide coverage and in  
80 accordance with accepted actuarial principles and practices.  
81 For purposes of regulations issued pursuant to this  
82 paragraph, medicare supplement policies issued as a result of  
83 solicitations of individuals through the mail or mass media  
84 advertising, including both print and broadcast advertising,  
85 shall be treated as individual policies.

86 (e) Disclosure standards.

87 (1) In order to provide for full and fair disclosure in the  
88 sale of accident and sickness policies, to persons eligible for  
89 medicare by reason of age, the commissioner may require by  
90 regulation that no policy of accident and sickness insurance  
91 may be issued for delivery in this state and no certificate may  
92 be delivered pursuant to such a policy unless an outline of  
93 coverage is delivered to the applicant at the time application  
94 is made.

95 (2) The commissioner shall prescribe the format and  
96 content of the outline of coverage required by paragraph one.  
97 For purposes of this paragraph, "format" means style,

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

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

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

105 (C) A statement of the renewal provisions including any  
106 reservation by the insurer of the right to change premiums;

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

110 (3) The commissioner may prescribe by regulation a  
111 standard form and the contents of an informational brochure  
112 for persons eligible for medicare by reasons of age, which is  
113 intended to improve the buyer's ability to select the most  
114 appropriate coverage and improve the buyer's understanding  
115 of medicare. Except in the case of direct response insurance  
116 policies, the commissioner may require by regulation that the  
117 information brochure be provided to any prospective  
118 insureds eligible for medicare concurrently with delivery of  
119 the outline of coverage. With respect to direct response  
120 insurance policies, the commissioner may require by  
121 regulation that the prescribed brochure be provided upon  
122 request to any prospective insureds eligible for medicare by  
123 reason of age, but in no event later than the time of policy  
124 delivery.

125 (4) The commissioner may further promulgate reasonable  
126 regulations to govern the full and fair disclosure of the  
127 information in connection with the replacement of accident  
128 and sickness policies, subscriber contracts or certificates by  
129 persons eligible for medicare by reason of age.

130 (f) Notice of free examination.

131 Medicare supplement policies or certificates, other than  
132 those issued pursuant to direct response solicitation, shall  
133 have a notice prominently printed on the first page of the  
134 policy or attached thereto stating in substance that the  
135 applicant shall have the right to return the policy or certificate  
136 within ten days from its delivery and have the premium  
137 refunded if, after examination of the policy or certificate, the  
138 applicant is not satisfied for any reason. Medicare  
139 supplement policies or certificates issued pursuant to a direct

140 response solicitation to persons eligible for medicare by  
141 reason of age shall have a notice prominently printed on the  
142 first page or attached thereto stating in substance that the  
143 applicant shall have the right to return the policy or  
144 certificate within thirty days of its delivery and to have the  
145 premium refunded if, after examination, the applicant is not  
146 satisfied for any reason.

147 (g) Administrative procedures.

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

151 (h) Separability.

152 If any provision of this section or the application thereof to  
153 any person or circumstance is for any reason held to be  
154 invalid, the remainder of the section and the application of  
155 such provision to other persons or circumstances shall not be  
156 affected thereby.

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

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

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

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

**ARTICLE 28. INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE  
MINIMUM STANDARDS.**

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

- 1 (a) Definitions.
- 2 (1) "Applicant" means in the case of an individual  
3 medicare supplement policy or subscriber contract, the  
4 person who seeks to contract for insurance benefits.
- 5 (2) "Medicare Supplement Policy" means an individual  
6 policy of accident and sickness insurance or a subscriber  
7 contract (of hospital and medical service associations) which  
8 is advertised, marketed or designed primarily as a  
9 supplement to reimbursements under medicare for the  
10 hospital, medical or surgical expenses of persons eligible for  
11 medicare by reason of age. Such term does not include:
- 12 (A) A policy or contract of one or more employers or labor  
13 organizations, or of the trustees of a fund established by one  
14 or more employers or labor organizations, or a combination  
15 thereof, for employees or former employees, or combination  
16 thereof, for members or former members, or combination  
17 thereof, of the labor organizations, or
- 18 (B) A policy or contract of any professional, trade or  
19 occupational association for its members or former or retired  
20 members, or combination thereof, if such association is  
21 composed of individuals all of whom are actively engaged in  
22 the same profession, trade or occupation; has been  
23 maintained in good faith for purposes other than obtaining  
24 insurance; and has been in existence for at least two years  
25 prior to the date of its initial offering of such policy or plan to  
26 its members.
- 27 (C) Individual policies or contracts issued pursuant to a  
28 conversion privilege under a policy or contract of group or  
29 individual insurance when such group or individual policy or  
30 contract includes provisions which are inconsistent with the  
31 requirements of this section.
- 32 (3) "Medicare" means the Health Insurance for the Aged  
33 Act, Title XVIII of the Social Security Amendments of 1965,  
34 as then constituted or later amended.

35 (b) Standards for policy provisions.

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37 establish specific standards for policy provisions of medicare  
38 supplement policies. Such standards shall be in addition to  
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51 that specify prohibited policy provisions not otherwise  
52 specifically authorized by statute which, in the opinion of the  
53 commissioner, are unjust, unfair or unfairly discriminatory to  
54 any person insured or proposed for coverage under a  
55 medicare supplement policy.

56 (3) Notwithstanding any other provisions of the law, a  
57 medicare supplement policy may not deny a claim for losses  
58 incurred more than six months from the effective date of  
59 coverage for a preexisting condition. The policy may not  
60 define a preexisting condition more restrictively than a  
61 condition for which medical advice was given or treatment  
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101 (C) A statement of the renewal provisions including any  
102 reservation by the insurer of the right to change premiums;

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

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109 intended to improve the buyer's ability to select the most  
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112 policies, the commissioner may require by regulation that the  
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132 within ten days from its delivery and have the premium  
133 refunded if, after examination of the policy or certificate, the  
134 applicant is not satisfied for any reason. Medicare  
135 supplement policies or certificates issued pursuant to a direct  
136 response solicitation to persons eligible for medicare by  
137 reason of age shall have a notice prominently printed on the  
138 first page or attached thereto stating in substance that the  
139 applicant shall have the right to return the policy or  
140 certificate within thirty days of its delivery and to have the  
141 premium refunded if, after examination, the applicant is not  
142 satisfied for any reason.

143 (g) Administrative procedures.

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

147 (h) Separability.

148 If any provision of this section or the application thereof to  
149 any person or circumstance is for any reason held to be  
150 invalid, the remainder of the section and the application of  
151 such provision to other persons or circumstances shall not be  
152 affected thereby.

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

R. P. Bayler  
Chairman Senate Committee

Jonny E. Whitlow  
Chairman House Committee

Originated in the Senate.

To take effect ninety days from passage.

Jodd C. Willis  
Clerk of the Senate

U. Blankenship  
Clerk of the House of Delegates

[Signature]  
President of the Senate

[Signature]  
Speaker House of Delegates

The within is approved this the 23  
day of April 1981.

[Signature]  
Governor



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