

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.

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

- 41 (A) Terms of renewability;
- 42 (B) Initial and subsequent conditions of eligibility;
- 43 (C) Nonduplication of coverage;
- 44 (D) Probationary period;
- 45 (E) Benefit limitations, exceptions and reductions;
- 46 (F) Elimination period;
- 47 (G) Requirements for replacement;
- 48 (H) Recurrent conditions; and
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50 (2) The commissioner may issue reasonable regulations
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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75 for which rates are computed to provide coverage and in
76 accordance with accepted actuarial principles and practices.

77 For purposes of regulations issued pursuant to this
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81 shall be treated as individual policies.

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95 as size, color and prominence of type and the arrangement of
96 text and captions. Such outline of coverage shall include:

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

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100 limitations contained in the policy;

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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112 policies, the commissioner may require by regulation that the
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114 insureds eligible for medicare concurrently with delivery of
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117 regulation that the prescribed brochure be provided upon
118 request to any prospective insureds eligible for medicare by

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

Tony E. Whitlow
Chairman House Committee

Originated in the Senate.

To take effect ninety days from passage.

Jodd C. Willis
Clerk of the Senate

Ch Blankenship
Clerk of the House of Delegates

Wm. B. Taylor
President of the Senate

Wm. H. Lee, Jr.
Speaker House of Delegates

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

John D. Rhyne
Governor



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SECY. OF STATE