WEST VIRGINIA LEGISLATURE

REGULAR SESSION, 1993

ENROLLED

SENATE BILL NO. 282

(By Senators Minard and Schmidt)

PASSED April 7, 1993

In Effect 90 days from Passage

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Senate Bill No. 282

(SENATORS MINARD AND HELMICK)

[Passed April 7, 1993; in effect ninety days from passage.]

AN ACT to amend and reenact section three-d, article sixteen, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended; and to amend and reenact section five-b, article twenty-eight of said chapter, all relating to medicare supplement insurance; revising the definition of medicare supplement policy; requiring disclosure in a medicare supplement policy of any automatic renewal premium increases based on a policyholder's age; increasing the free examination period from ten to thirty days for a medicare supplement policy issued other than by direct response solicitation; requiring that any premium refund requested pursuant to a free examination of such a policy be paid directly to the policy applicant in a timely manner; and making technical corrections.

Be it enacted by the Legislature of West Virginia:

That section three-d, article sixteen, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted; and that section five-b, article twenty-eight of said chapter be amended and reenacted, all to read as follows:

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§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 certificate holder.

(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 corporations or health maintenance organizations), other than a policy issued pursuant to a contract under Section 1876 or 1833 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act, 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.

(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 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 and 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) above. 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.

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 corporations or health maintenance organizations), other than a policy issued pursuant to a contract under Section 1876 or 1833 of the federal Social Security Act

(42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act, 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) above. 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.

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

Chairman Senate Committee

Ernest C. Moore
Chairman House Committee

Originated in the Senate.

In effect ninety days from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker House of Delegates

The within is approved this the 22nd day of April, 1993.

Governor

PRESENTED TO THE
GOVERNOR
Date 4/16/93
Time 9:26 am