WEST VIRGINIA LEGISLATURE

2016 REGULAR SESSION

Introduced

Senate Bill 512

BY SENATORS LAIRD, MILLER, SNYDER AND UNGER

[Introduced February 4, 2016;

Referred to the Committee on Banking and Insurance; and

then to the Committee on the Judiciary.]

A BILL to amend and reenact §33-16-3d of the Code of West Virginia, 1931, as amended, relating to Medicare supplement insurance; requiring an insurer to reinstate a Medicare supplement insurance policy after terminating same for nonpayment of premium upon receiving proof that the insured failed to pay due to becoming incompetent; providing that proof of the existence of a conservatorship within a certain timeframe for the insured constitutes sufficient proof that nonpayment of premium was due to incompetency; and providing that proof of the existence of a durable power of attorney along with a medical physician’s affidavit which states that an insured’s failure to pay premium was due to incompetency, provided within in a certain timeframe, is sufficient to require the insurance carrier to reinstate the policy upon payment of the premium.

Be it enacted by the Legislature of West Virginia:

That §33-16-3d of the Code of West Virginia, 1931, as amended, be amended and reenacted 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 or 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. §1395, et seq.) or an issued policy under a demonstration project specified pursuant to amendments to the federal Social Security Act 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;

(B) Medicare advantage plans established under Medicare Part C, outpatient prescription drug plans established under Medicare Part D, or any health care prepayment plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

(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.

(4) Notwithstanding any provisions of the law, a Medicare supplement policy shall reinstate coverage that was terminated due to failure to pay a premium, without any requirement of the existence of open enrollment, upon payment of the past due premium in conjunction with proof that such failure of payment was caused due to incompetency or incapacity of the insured, made to the insurer within six months from the date the last premium was due. The proof required under this subdivision is considered sufficient in the event of either of the following contingencies:

(A) A conservator, as defined by subsection one, section four, article one, chapter forty-four-a of this code, has been appointed by a circuit court to manage the financial affairs of the insured and the proof of such conservatorship is provided to the insurer within six months from the date the last premium was due and upon which the nonpayment of the premium led to the termination of the Medicare supplement policy; or

(B) A durable power of attorney, as prescribed under article one, chapter thirty-nine-b of this code, has been executed and is in full force and effect, authorizing a person to handle the business affairs of the insured, including receiving funds on behalf of the insured and paying debtors on behalf of the insured, and a copy of the power of attorney is provided to the insurer along with a medical physician’s affidavit that the insured’s mental incompetence contributed to his or her omission to pay the required insurance premium, within six months from the date the

last premium was due and upon which the nonpayment of the premium led to the termination of the Medicare supplement policy.

(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.

NOTE: The purpose of this bill is to require an insurer to reinstate a Medicare supplement insurance policy after terminating the policy for nonpayment of premium upon providing payment of the past due premium along with sufficient proof that the insured failed to pay due to becoming incompetent. The bill also provides that proof of the existence of a conservatorship for the insured, provided to the insurer within a certain time frame, constitutes sufficient proof that nonpayment of premium was due to incompetency. Additionally the bill provides that proof of the existence of a durable power of attorney along with a medical physician's affidavit stating that the insured's failure to pay premium was due to incompetency which is provided within a certain timeframe, is sufficient to require the insurance carrier to reinstate the policy upon payment of the premium.

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Strike-throughs indicate language that would be stricken from a heading or the present law, and underscoring indicates new language that would be added.