WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #3

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1990 AUG 10 PM 3:36

NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY W.Va. Code §§ 33-2-10, 33-6-8, 33-6-9, 33-25A-3(1), 33-25A-20, 16-3C-2(j)

AMENDMENT TO AN EXISTING RULE: YES___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: 27

TITLE OF RULE BEING PROPOSED: AIDS Regulations

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

B. Keith Huffman
General Counsel

STATE OF WEST VIRGINIA

GASTON CAPERTON
GOVERNOR

HANLEY C. CLARK
INSURANCE COMMISSIONER

OFFICES OF THE
INSURANCE COMMISSIONER
2019 WASHINGTON STREET, EAST
CHARLESTON, WEST VIRGINIA 25305

LEGAL DIVISION
304) 348-0401

FACSIMILE
(304) 348-0412

August 10, 1990

HAND DELIVERED

Ms Judy Cooper
Office of Secretary of State
State Capitol
Charleston, WV 25305

Re: AIDS Regulations (Series 27)

Dear Ms Cooper:

Enclosed please find for filing the "Notice of Agency Approval of a Proposed Rule and Filing with the Legislative Rule-Making Review Committee," "Description of Rule," "Legislative Rule-Making Review Committee Questionnaire" and a copy of the proposed rule "AIDS Regulations" for Series 27, Title 114.

Sincerely,

B. Keith Huffman

B. Keith Huffman
General Counsel

BKH/iw
Enclosures

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER

DATE: August 10, 1990

LEGISLATIVE RULE TITLE: AIDS Regulations
(Series 27)

1. Authorizing statute(s) citation West Virginia Code §§ 33-2-10, 33-6-8, 33-6-9, 33-25A-3(1), 33-25A-20, 16-3C-2(j)

2. a. Date filed in State Register with Notice of Hearing:

May 31, 1990

b. What other notice, including advertising, did you give of the hearing?

None

c. Date of hearing(s): The public comment period ended on July 2, 1990, at 4:30 p.m.

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached X No comments received ____

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)

August 10, 1990

f. Name and phone number of agency person to contact for additional information:

B. Keith Huffman

General Counsel

348-0401

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

Not applicable

b. Date of hearing: Not applicable

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

Not applicable

d. Attach findings and determinations and reasons:

Attached Not applicable

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER

DATE: August 10, 1990

LEGISLATIVE RULE TITLE: AIDS Regulations
(Series 27)

DESCRIPTION OF RULE

The Insurance Commissioner regulates Life and Accident Insurance policies. There is much concern as to what information insurers may request and when and how insurers may require HIV testing of insurance applicants.

This rule sets out guidelines which insurers must follow in underwriting for HIV in regard to Life and Accident and Sickness Insurance policies. Inter alia, it prohibits questions relating to sexual preference or life-style and limits HIV testing as to group insurance policies.

WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

CHAPTER 33
SERIES 27

AIDS REGULATIONS

WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

Chapter 33
Series 27

AIDS REGULATIONS

Section 1. General

1.1 Scope - This legislative rule establishes standards for AIDS related underwriting questions and AIDS testing in connection with applications for life or health insurance policies.

1.2 Authority - West Virginia Code §§ 33-2-10, 33-6-8, 33-6-9, 33-25A-3(1), 33-25A-20, and ~~16-3C-2(i)~~ 16-3C-2(j).

1.3 Filing Date -

1.4 Effective Date -

Section 2. Applicability

2.1 Insurers - All insurers who deliver or issue for delivery in this state any policies for life or accident and sickness insurance are subject to this regulation.

2.2 Service Corporations - All health service corporations who deliver or issue for delivery in this state any subscriber's contracts for health insurance are subject to this regulation.

2.3 Health Care Corporations - All health care corporations who issue to enrollees in this state evidence of health insurance coverage are subject to this regulation.

2.4 Fraternal Benefit Societies:

(A) All fraternal benefit societies who deliver or issue for delivery life insurance benefit certificates in this state are subject to this regulation.

(B) All domestic, foreign, or alien societies who issue any certificate or other evidence of any contract of accident or sickness insurance in this state.

2.5 Health Maintenance Organizations - All health maintenance organizations who deliver or offer for delivery in this state any evidence of coverage are subject to this regulation.

Section 3. Definitions

3.1 Code - ~~shall~~ means the West Virginia Code.

3.2 Commissioner - ~~shall~~ means the Insurance Commissioner of the State of West Virginia.

3.3 Acquired Immunodeficiency Syndrome (AIDS) - ~~shall mean a disease indicative of underlying cellular immunodeficiency~~ means the acquired immunodeficiency syndrome as may be from time to time defined by the Centers for Disease Control of the United States Public Health Service.

3.4 AIDS Related Complex (ARC) - ~~shall~~ means a syndrome in which the individual displays many of the same symptoms of AIDS, including the presence of the HIV antibody.

3.5 Human Immunodeficiency Virus (HIV) - ~~shall~~ means the virus responsible for the potential development of the Acquired Immunodeficiency Syndrome (AIDS).

~~3.6 Human T-Cell Lymphotrophic Virus (HLTV-III) - shall mean antibodies present in the blood that normally indicate exposure to the HIV virus.~~

~~3.7~~ 3.6 Enzyme Linked ~~Immunoasorbent~~ Immunosorbent Assay (ELISA) - ~~shall~~ means a test ~~utilized~~ used to determine the existence of the HIV antibody in the blood.

~~3.8~~ 3.7 Insurer - ~~shall~~ includes all entities providing life or accident and sickness coverage.

3.8 Western Blot - means a test used to determine the existence of the HIV antibody in the blood.

3.9 Health Care Professional or Health Care Provider - means any physician, nurse, physicians assistant, or any other person providing medical, dental, nursing or other health care services of any kind.

Section 4. Medical/Lifestyle Applications Questions and Underwriting Guidelines

4.1 General Propositions:

(A) No inquiry in an application for health or life insurance coverage, or in an investigation conducted by an

insurer or an insurance support organization on its behalf in connection with an application for such coverage shall be directed toward determining the ~~applicant's~~ proposed insured's sexual orientation.

(B) Sexual orientation may not be used in the underwriting process or in the determination of insurability.

(C) Insurance support organizations shall be directed by insurers not to investigate, directly or indirectly, the sexual orientation of ~~an applicant~~ a proposed insured or beneficiary.

4.2 Medical/Lifestyle Applications Questions and Underwriting Standards.

(A) No question shall be used which is designed to establish the sexual orientation of the ~~applicant~~ proposed insured.

(B) Questions relating to the ~~applicant~~ proposed insured having or having been diagnosed as having AIDS or ARC are permissible if they are factual and designed to establish the existence of the condition.

For Example: Insurers should not ask "do you believe you may have . . .?", but rather "do you know or have reasons to know . . .?"

(C) Questions inquiring as to whether the ~~applicant~~ proposed insured has ever tested positive for the presence of the HIV virus or HIV virus antibodies are permissible, however, questions inquiring as to whether the ~~applicant~~ proposed insured has ever been tested for the presence of the HIV virus or HIV antibodies are prohibited.

(D) Questions relating to medical and other factual matters intending to reveal the possible existence of a medical condition are permissible if they are not used as a proxy to establish the sexual orientation of the ~~applicant~~ proposed insured, and the ~~applicant~~ proposed insured has been given an opportunity to provide an explanation for any affirmative answers given in the application

For Example: "Have you had chronic cough, significant weight loss, chronic fatigue, diarrhea, enlarged glands, . . .?" would be permissible. These questions must relate to a definite time period immediately ~~preceeding~~ preceding the application and

must be specific. The ~~applicant~~ proposed insured shall be given the opportunity to explain the described symptoms.

(E) Questions relating to the ~~applicant's~~ proposed insured's having or having been advised to seek treatment by a medical doctor, health nurse or other medical professional for a sexually transmitted disease are permissible.

(F) Neither the marital status, the "living arrangements," the occupation, the gender, the medical history, the beneficiary designation, nor the zip code or other territorial classification of ~~an applicant~~ a proposed insured may be used to establish, or aid in establishing, the ~~applicant's~~ proposed insured's sexual orientation.

(G) For purposes of rating ~~an applicant~~ a proposed insured for health and life insurance, an insurer may impose territorial rates, but only if the rates are based on sound actuarial principles or are related to actual or reasonably anticipated experience.

For Example: If a particular territory demonstrates a general propensity for high risk, an insurer may impose a rate higher for that territory than for similar risks located in other territories.

(H) No questions shall seek to determine if the ~~applicant~~ proposed insured has demonstrated AIDS-related concerns or has sought AIDS-related counseling.

(I) No adverse underwriting decision shall be made because medical records or a report from an insurance support organization show(s) that the ~~applicant~~ proposed insured has demonstrated AIDS-related concerns or has sought counseling. This subsection does not apply to ~~an applicant~~ a proposed insured seeking treatment and/or diagnosis.

Section 5. Testing

5.1 AIDS-related testing in connection with the application for group life or accident and sickness insurance is prohibited; provided that an insurer may conduct such testing in relation to the application for group accident insurance when the insurance applied for is otherwise individually underwritten and evidence of insurability is otherwise required by the insurer.

5.2 Whenever ~~an applicant~~ a proposed insured is requested to take an AIDS-related test in connection with an application for insurance, the use of such a test must be revealed to the ~~applicant~~ proposed insured and his or her written, informed consent obtained.

5.3 The ~~applicant~~ proposed insured should demonstrate an ~~actual~~ understanding that the test is being performed, of the nature of the test, of the persons to whom the results of that test may be disclosed, of the purpose for which test results may be used, of any limitations on the accuracy and meaning of the test results, and of any foreseeable risks and benefits resulting from the test.

5.4 The person requesting the test, and not the individual or individual's health care provider, must underwrite the cost of the test.

5.5 The individual undergoing the test has a choice to receive the test result directly or to designate in writing, prior to the administration of the test, any other person, such as a health care professional or clergyman, who may receive the results.

~~5.6 Except as specified in section 5.5 above, the insurer and it's agents shall not release or disclose either that the test has been conducted or the test results to any other party. Such information shall specifically not be released to any insurance support or information sharing organization such as the Medical Information Bureau (MIB) or to reinsurers, provided that the health care professional performing the test may release the test results to the insurer which requested the test and to such other parties and under such conditions as are dictated by West Virginia Code §§ 16 3C 3 and 33 3C 4.~~

5.6 The insurer and its agents shall not release or disclose either that a HIV test has been conducted or the test results to any other party except under the following limited circumstances:

(A) Negative test results only may be disclosed to a reinsurer where either:

(1) The reinsurer is to reinsure a portion of the risk on a facultative basis; or

(2) The reinsurer is to reinsure a portion of a block of business on a treaty basis and where the release of HIV test information is disclosed by the ceding insurer only to the

extent that the reinsurer is permitted to perform limited audits of the ceding insurers underwriting files to verify that proper HIV underwriting has occurred.

(B) Positive test results only may be disclosed to the Medical Information Bureau (MIB) provided that such information release is limited to a coded report identified only as a nonspecific abnormal blood test code.

(C) To the extent necessary to allow them to properly perform the functions for which their services were contracted by the insurer, an insurer may disclose HIV test information to certain contractors of the insurer such as audit firms, third party underwriters and claims adjusting firms.

(D) To the extent that they are otherwise entitled to access to the insurers files, government agencies may be permitted access to files containing HIV test information.

5.7 The testing is required to be administered on a nondiscriminatory basis for all individuals in the same class and no proposed insured may be denied coverage or rated a substandard risk on the basis of such testing unless acceptable testing protocol is followed. The insurer may at its option use a urine HIV test as an initial screening device; provided that if such urine test yields a negative result no further HIV testing may be required of the proposed insured. If the urine test yields a positive result for the presence of HIV antibodies then HIV blood testing may be required by the insurer. The proposed insured may not be denied insurance coverage or rated a substandard risk on the basis of a positive urine HIV test alone. The following is the acceptable blood HIV testing protocol for use in this state and an insured may not be denied coverage on the basis of AIDS related ~~questions~~ testing unless:

(A) An initial enzyme linked ~~immunoasorbent~~ immunosorbent assay (ELISA) blood test is administered to the proposed insured, and it indicates the presence of HIV antibodies in the blood; and

(B) A second ELISA blood test is administered and it indicates the presence of HIV antibodies in the blood; and

(C) A Western Blot blood test is conducted and it confirms the results of the two ELISA tests.

5.8 If any of the test results in the ELISA-ELISA-Western Blot series produce a negative result, the testing ceases and

the ~~applicant~~ proposed insured cannot be denied coverage based on AIDS-related ~~concerns~~ testing.

For Example: If the initial ELISA test yields a negative result, the testing ceases. If the initial ELISA test yields a positive result and the subsequent ELISA test yields a negative result, the testing ceases. If both ELISA tests yield a positive result and the Western Blot test yields a negative result, for purposes of insurability, the results are negative.

5.9 News of a positive test result could result in serious emotional trauma to the ~~applicant~~ proposed insured. For this reason, it is recommended that the insurer recommend to the proposed insured that positive results be communicated to the ~~applicant~~ proposed insured face to face by a qualified health care professional who could provide AIDS counseling.

Section 6. Notice and Consent Form

6.1 A notice and consent form must be executed by each ~~applicant~~ proposed insured before AIDS-related testing is performed as to such ~~applicant~~ proposed insured on behalf of any insurer.

6.2 The notice and consent form required by section 6.1 shall be as is set out in Appendix A attached hereto.

Section 7. Separability

7.1 If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application thereof to other persons or circumstances shall not be affected thereby.

Insurance Commissioner
Leg. Rule 33
Series 27

APPENDIX A

Examiner _____ Insured _____
Address _____ Address _____
_____ _____

NOTICE AND CONSENT FOR BLOOD OR URINE TESTING
WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood or urine for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS Virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. ~~These~~ This series of tests ~~are~~ is extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

~~All tests results will be treated confidentially. They will be reported by the laboratory to the Insurer. There will be no other disclosure by the insurer of test results or even that the tests have been done.~~

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

APPENDIX A

~~Also you may direct that test results be disclosed directly to you, or if you prefer to your personal physician or other health care provider. (Indicate in appropriate area below.)~~ You should also be aware that the health care professional who performs the blood testing is subject to West Virginia Code §§ 16-3C-3 and 16-3C-4 which authorizes that they may disclose test results to certain limited individuals under certain limited circumstances [these relate primarily to (1) persons you authorize to see the test results, (2) health care providers who may come into contact with you or specimens obtained from you, (3) the United States centers for disease control, (4) a court order to release the results, and (5) identified sex partners and persons sharing needles.] These persons are required by West Virginia Code §§ 16-3C-3 and 16-3C-4 to keep test information confidential. ~~(A copy of §§ 16-3C-3 and 16-3C-4 are attached for your futher information.)~~

You may direct that test results be disclosed directly to you or if you prefer to your personal physician or other health care professional. It is strongly suggested that you designate a physician or health care professional to receive your test results so that they may properly explain the results to you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which in the Insurer's opinion, are significant. If you have not already indicated one, the Insurer may ask you at that time for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

APPENDIX A

~~Also you may direct that test results be disclosed directly to you, or if you prefer to your personal physician or other health care provider. (Indicate in appropriate area below.)~~ You should also be aware that the health care professional who performs the blood testing is subject to West Virginia Code §§ 16-3C-3 and 16-3C-4 which authorizes that they may disclose test results to certain limited individuals under certain limited circumstances [these relate primarily to (1) persons you authorize to see the test results, (2) health care providers who may come into contact with you or specimens obtained from you, (3) the United States centers for disease control, (4) a court order to release the results, and (5) identified sex partners and persons sharing needles.] These persons are required by West Virginia Code §§ 16-3C-3 and 16-3C-4 to keep test information confidential. ~~(A copy of §§ 16-3C-3 and 16-3C-4 are attached for your futher information.)~~

You may direct that test results be disclosed directly to you or if you prefer to your personal physician or other health care professional. It is strongly suggested that you designate a physician or health care professional to receive your test results so that they may properly explain the results to you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which in the Insurer's opinion, are significant. If you have not already indicated one, the Insurer may ask you at that time for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

APPENDIX A

I wish my test results to be released to:

(~~Initial~~ Check Please)

_____ Myself only.

_____ My physician, health care provider, or other person indicated below.

_____ Both myself and my physician, health care provider or other person indicated below.

Physician, Health Care Provider, or other person.

Name: _____

Address: _____
_____

I have read and I understand this Notice and Consent For Blood or urine Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to give a urine specimen and/or to the withdrawal of blood from me, ~~by needle,~~ the testing of that urine and/or blood, and the disclosure of the test results as described.

~~Authorization period for this consent form~~ expires _____.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____
Proposed Insured Date of Birth

_____ _____ _____
Signature of Proposed Insured or Parent/Guardian Date State of Residence

THIS AUTHORIZATION EXPIRES AFTER 60 DAYS

APPENDIX A

I wish my test results to be released to:

(~~Initial~~ Check Please)

_____ Myself only.

_____ My physician, health care provider, or other person indicated below.

_____ Both myself and my physician, health care provider or other person indicated below.

Physician, Health Care Provider, or other person.

Name: _____

Address: _____
_____

I have read and I understand this Notice and Consent For Blood or urine Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to give a urine specimen and/or to the withdrawal of blood from me, ~~by needle,~~ the testing of that urine and/or blood, and the disclosure of the test results as described.

~~Authorization period for this consent form~~ expires _____.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____
Proposed Insured Date of Birth

_____ _____ _____
Signature of Proposed Insured or Parent/Guardian Date State of Residence

THIS AUTHORIZATION EXPIRES AFTER 60 DAYS

ATTACHMENT TO QUESTION 2(d)

Comments concerning the proposed rule were received from the following: The Principal Financial Group (Principal Mutual Life Insurance Company); American Council of Life Insurance; Massachusetts Mutual Life Insurance Company; Health Insurance Association of America; John Alden Life Insurance Company; MIB, Inc. (Medical Information Bureau); State Farm Insurance Companies; Mutual of Omaha Companies; Transamerica Life Insurance Companies; CNA Insurance Companies; Lincoln National Corporation; AETNA Life Insurance Company and AETNA Casualty Surety Company; Northwestern Mutual Life Insurance Company; The Prudential Insurance Company of America; New England Mutual Life Insurance Company; Provident Companies.

After reviewing the comments, the Department determined that several amendments to the proposed rule were appropriate. Also, several "clean up" amendments were made by the Department. These amendments are indicated by stricken and underlined language in the proposed rule. Amendments made pursuant to comments received are as follows:

The first amendment is to correct a typographical error in section 1.2 which is self explanatory. The second amendment concerns section 3.3 which defines Acquired Immunodeficiency Syndrome (AIDS). Several commentators offered alternative definitions to that which was set out in the original rule. The thrust of these comments was that the definition was too broad and that it did not allow for a changing understanding of the AIDS virus as it develops in the medical community. The

Department amended this section accordingly with a more narrow definition which allowed for the continued refinement of the understanding of the AIDS virus as pronounced by the centers for disease control of the United States public health service.

The third amendment concerns section 3.6 which defines Human T-Cell Lymphotrophic Virus (HTLV III). A commentator pointed out that this definition was not used in the remainder of the rule and therefore could be eliminated so as to avoid confusion. Accordingly, the Department elected to eliminate this definition from the rule. The fourth amendment relates to section 3.7 defining Enzyme Linked Immunosorbent Assay (ELISA). This is a housekeeping amendment by the Department to clarify the definition.

The fifth amendment concerns section 3.7 where the Department inserted a definition of Western Blot. This was a housekeeping measure in the interest of clarity.

The sixth amendment relates to what in the amended version is section 3.8. One commentator maintained that the terms "health care professional" and "health care provider" should be given a definition. Such definitions were accordingly added to the rule.

The seventh amendment first appears in section 4.1(A) and carries throughout the remainder of the rule. One commentator pointed out that references to "the applicant" in the rule could more accurately be phrased as "the proposed insured." The Department agreed and amended the rule accordingly. Therefore, the term "applicant" throughout the rule was changed to "proposed insured". The eighth amendment relates to section

4.2(D) of the rule. One commentator misunderstood the example set out under this section as being an example of a question which would not be permissible for insurers to use. In fact, this is an example of a question which would be permissible for use. Therefore, the words "would be permissible" were added to the first sentence of the example for clarification.

The ninth amendment relates to section 5.1. The original reason for the general prohibition of AIDS-related testing in connection with group insurance was that in a true group situation, insureds are accepted into the group with no individual underwriting. Numerous commentators pointed out circumstances in which individual underwriting may be performed in a group setting. Consequently, the Department amended the rule so that it generally prohibits AIDS testing for group insureds where individual underwriting is not otherwise performed, but permits it in situations where underwriting is otherwise done on an individual basis.

The tenth amendment relates to section 5.3. Several commentators opined that it would be difficult if not impossible to show that a proposed insured had an actual understanding of the HIV test and its surroundings. Consequently, the Department elected to remove the word "actual" from this section.

The eleventh amendment relates to section 5.6. Numerous commentators argued that there are overriding business purposes for disclosure by an insurer of AIDS test information to certain industry groups. Primarily, these groups were the Medical Information Bureau (MIB), reinsurers, contractors, and insurance

company affiliates. After a great deal of consideration, the Department decided that there was validity to some of these arguments and that amendments to the rule were necessary so as not to disrupt legitimate insurance business practices. However, the Department wanted to make these amendments as carefully tailored as possible so as to protect the privacy interests of proposed insureds. Therefore, section 5.6 was rewritten to permit disclosure under limited circumstances to the MIB, insurance contractors who are necessary to the insurer's business, and to reinsurers only to the extent necessary for the establishment of reinsurance on the insurer's book of business. It was felt that disclosure to insurance company affiliates was unnecessary unless they were performing a function as a contractor on behalf of the insurer. This practice would be handled under the amendment dealing with contractors.

The twelfth amendment relates to section 5.7. One commentator expressed concerns that the rule may not permit the use of HIV urine testing. The Department felt that this was legitimate concern and the use of non-invasive urine testing should definitely be permitted and addressed by the rule. Therefore, language was inserted to specifically permit urine HIV testing and in what manner it could be used. A drafting error was also corrected in this section where the word "questions" was replaced with the proper word which should have been "testing". The thirteenth amendments relates to section 5.8 where a drafting error was corrected and the word "concerns" was replaced with the proper word "testing".

The fourteenth amendment relates to section 5.9. Several commentators felt that there was a conflict between section 5.9 and section 5.5 relating to whether the proposed insured would receive test results in person or whether the test results would be communicated to the proposed insured by a qualified health care professional. It was the desire of the Department to preserve free choice on behalf of the proposed insured while at the same time communicating to the proposed insured that it may be desirable to receive the test results from a health care professional. Therefore, additional language was added to suggest that the insurer recommend to the proposed insured that they designate a health care professional to receive test results, but which still allows that final decision to be made by the proposed insured.

The fifteenth amendments relate to Appendix A of the rule. Appendix A was amended in several respects so that it would correspond to the amendments made in the text of the rule as discussed above. The first of these amendments is the addition of the words "or urine" in the appropriate places so that the consent form would accommodate either blood or urine testing. The second amendment is a clean up measure in the second paragraph of Appendix A whereby the language "These tests are" was changed to "This series of tests is". It was felt by the Department that this is a more accurate statement since the high reliability of HIV testing is due largely to the completion of the entire series as opposed to reliance on individual tests. The third amendment to Appendix A is a rewrite of the third

paragraph such that the disclosure by the Insurer to those entities permitted under section 5.6 of the regulation is discussed.

The fourth amendment to Appendix A is in the fourth paragraph where the language relating to the attachment of a copy of West Virginia Code §§ 16-3C-3 and 16-3C-4 was eliminated. This was in response to several comments from commentators which felt that the attachment of the West Virginia Code provisions was unnecessary overkill and may confuse the proposed insured.

The fifth amendment to Appendix A relates to the insertion of a paragraph between the fourth and fifth paragraphs in order to clarify that while it is strongly suggested that the proposed insured designate a health care professional to receive test results, that the decision was up to the proposed insured. The sixth amendment to Appendix A is on page 2 and relates to the designation by the proposed insured of who is to receive test results. Several commentators indicated that past experience showed that forms which request an applicant to initial are often misread or improperly completed and that a simple check would be preferential. The Department amended this section accordingly.

The seventh amendment to Appendix A is on the third page and relates to the expiration of the authorization period for the consent form. Several commentators pointed out that the use of a set expiration period would be much more administratively practical than the designation of an arbitrary period by the

proposed insured. The Department agreed and adopted this suggestion.

The Department also received a number of comments which were not incorporated into the proposed rule. The following discusses those comments and the reasons the comments were rejected.

Several commentators questioned whether the proposed rule went beyond the statutory authority of the insurance commissioner. These comments relied principally upon two court cases in other jurisdictions. Both these cases involved situations where the state agency involved in the promulgation of the rules which were stricken down had no specific authority to promulgate regulations. An examination of the enabling legislation set out as justification for this set of rules clearly demonstrates that the West Virginia insurance commissioner has the necessary authority to promulgate the same. Further, amendments made to the rule as a result of other comments received substantially lessen the impact of the rules and remove even any arguable doubt as to the insurance commissioner's authority to promulgate these rules.

Several commentators offered alternative definitions to those set out at sections 3.3, 3.4 and 3.5. An examination of these alternative definitions revealed that while the wording was somewhat different from those in the proposed rule, the substance was essentially the same. Therefore, the original language was retained.

One commentator disagreed with the prohibition of insurer questions relating to whether an individual has taken prior

negative HIV tests as set out at section 4.2(C). It was felt that this prohibition was consistent with the essential thrust of the entire set of rules and to remove this prohibition would be contrary to that overriding purpose. That is the protection of individual's privacy rights and the limitation of an insurer's ability to intrude on that privacy unless absolutely necessary. An insurer should have no right to pry into the fact that an individual has had HIV testing performed previously as long as there were negative test results.

The same commentator maintained that with regard to section 4.2(H) that the language "this subsection does not apply to an applicant seeking treatment and/or diagnosis" should be added to the end of such subsection. The Department concluded that the additional language was unnecessary and would cause confusion whereas subsection (H) deals with AIDS-related concerns and AIDS-related counseling and not AIDS treatment.

One commentator noted that the term "class" as used in section 5.7 was not defined. The Department determined that the term "class" and the use of classes in insurance underwriting is a term of art in that industry. It was felt that efforts to further define that term would only cause confusion and create artificial impediments to the enforcement of this rule.

Numerous commentators maintain that the testing protocol set out in section 5.7 should be changed to permit a negative underwriting decision to be made based on two out of three positive HIV results in the ELISA-ELISA-Western Blot series. This contention was rejected due to the fact that the ELISA test

was designed as a blood screening device to be used by blood banks and is well known to be overly sensitive. If the ELISA test renders erroneous results, it is nearly always a false positive. Since this is true, a negative ELISA test result will almost always be accurate. It was determined that the equities of this situation should favor the proposed insured and that they should not be subjected to further blood draws if a negative result is obtained. The very rare case where a person who is in fact HIV positive nonetheless obtains a negative HIV ELISA test result will not occur with sufficient regularity as to have any large impact upon insurers.

One commentator requested that section 6.2 be amended to permit the insurer to "personalize" the consent form as set out in Appendix A to the rule. It was determined that the consent form would be more clear and understandable to the insured if this were not done. The use of such words as "we," "us" and "our" could serve only to confuse the insured as to the roles of the parties involved in the testing process.

Another commentator maintained that Appendix A should be amended so as to eliminate the listing of persons to whom physicians or other medical personnel may release AIDS-related test information. The position was that since it was the medical professional and not the insurer who may have to release this information, the listing should be removed from the consent form. It was determined that this was a highly artificial position, since it is the insurer who is initiating the testing process and by whose request the medical professional is performing the blood testing.

Still another commentator maintained that it was not helpful to list the individuals to whom test information might be released in Appendix A and that this may overload the proposed insured with information. This contention was rejected since the purpose of the consent form is to insure that informed consent is given. An individual submitting to HIV testing should be aware, as much as possible, of all parties to whom this information may be disclosed.

JUL 02 '90 15:01

the Principal Financial Group

Principal Mutual
Life Insurance Company

FACSIMILE TRANSMITTAL SHEET

DATE: July 2, 1990

TO: B. Kenneth Huffman

TELEPHONE NO: 304 - 348 - 3354

TELEPHONE NO. OF FACSIMILE MACHINE: 304 - 348 - 0412

FROM: Merle Pederson

TELEPHONE NO: 515 - 248 - 2186

NO. OF PAGES (INCLUDING THIS COVER SHEET): 3

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PRINCIPAL MUTUAL LIFE INSURANCE COMPANY LEGAL DEPT. FACSIMILE TELEPHONE NO. IS 515-248-3011. PLEASE SEND RETURN TRANSMISSIONS TO THAT NUMBER.

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Mailing Address: Des Moines, Iowa 50392-0001 (515) 247-5111

the Principal
Financial Group

Principal Mutual
Life Insurance Company

July 2, 1990

FAX (304) 348-0412

B. Kenneth Huffman, Esq.
General Counsel
Office of Insurance Commissioner
State of West Virginia
2019 Washington Street, East
Charleston, West Virginia 25305

Re: Proposed AIDS Regulations

Dear Mr. Huffman:

I am writing on behalf of Principal Mutual Life Insurance Company to express our concerns regarding certain provisions of the proposed West Virginia AIDS regulations. As you may know, The Principal is among the ten largest United States insurance companies and last year ranked 5th in total premium volume. A large part of that business is in the Group Health and Life insurance markets. Because the proposed AIDS regulations appear to conflict with general insurance business practice and the regulatory direction taken in other states on this subject, we felt compelled to discuss those concerns with you.

Section 5.1 of the proposed regulations prohibits "AIDS-related testing in connection with the application for group life or accident and sickness insurance." This is perhaps the most disconcerting provision of the proposed regulations. As you know, many insurers (including The Principal) do insure small groups with fewer than 25 members. However, in order to insure these small groups, it is necessary to do more extensive underwriting than is performed on very large groups. Section 5.1 of the proposed regulation would prohibit an obviously key element in the underwriting process for issuing small group health insurance in particular. In addition, underwriting is often required to prevent adverse selection in the group life insurance setting where very high optional amounts of life insurance are being applied for by individuals within a group. For the same reason, underwriting for "late entrants" into a group is permitted by law and is consistent with general industry standards and practices. Section 5.1 will seriously disrupt the underwriting processes for all three of these situations and would, in our opinion, affect the availability and affordability of insurance to these groups. Accordingly, we would respectfully request that Section 5.1 of the regulations be deleted.

Section 5.3 of the proposed regulations requires that "the applicant should demonstrate an actual understanding that the test is being performed ..." It is unclear what the Department intends by this requirement. What is an "actual understanding"? What responsibilities do insurers have in maintaining documentary proof of this "actual understanding"? We would

suggest that the traditional informed consent regulatory provisions more than adequately advise and educate applicants regarding the nature and purpose of HIV tests. We would, therefore, respectfully request that this provision be eliminated.

The disclosure provisions found in Section 5.6 of the proposed regulations are very restrictive. Specifically, as you know, many insurers (including The Principal) are under contract with the Medical Information Bureau to provide generically-coded information which can be relied upon by the industry for a number of purposes, including underwriting. In addition, Section 5.6 of the proposed regulations would draw into question our legal obligation to comply with court orders or other state laws requiring our disclosure of test information. Accordingly, we would request that Section 5.6 be amended to allow the release of information to the Medical Information Bureau and the release of such information "where otherwise required by law." Without amendment, this portion of the regulation would deviate from the standard practice in every other state.

Finally, Section 5.8 of the proposed regulation would prohibit insurers from denying coverage based on AIDS test results where a series of tests have been conducted and a negative result was reached in any one of the tests. We would suggest that insurers be allowed to confirm an initial positive ELISA test result by performing a second ELISA test and if that test is negative, to confirm that result either through another ELISA or the Western Blot test. If the original ELISA test result is negative, we agree that further testing should not be required. However, where the initial result is positive, it is only fair and accurate that the entire series of test be run to achieve the most accurate results possible. Accordingly, we would suggest that the language in Section 5.8 be amended to read as follows:

> "If an initial test result from the ELISA-ELISA-Western Blot series produces a negative result, the testing ceases and the applicant cannot be denied coverage based on AIDS-related concerns."

We hope these comments are helpful to the Department in its deliberations. Please do not hesitate to contact us if you have questions regarding this matter.

Sincerely,

Merle T. Pederson
Attorney

MTP/ep

cc: Kirk Cunningham Greg Haessler Liz Kincaid Carl Peters

J. Bruce Ferguson, Legislative Director, ACLI

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the Principal Financial Group

American Council of Life Insurance

J. Bruce Ferguson
Legislative Director

June 29, 1990

B. Keith Huffman, Esq.
General Counsel
Office of the Insurance Commissioner
2019 Washington St., East
Charleston, WV 25305

Re: Proposed AIDS Regulation (Chapter 33, Series 27)

Dear Mr. Huffman:

This statement is submitted on behalf of the American Council of Life Insurance ("ACLI"), a trade association comprised of 616 companies which have 93.6 percent of the life insurance in force in the United States in legal reserve life insurance companies. Three hundred and ninety-seven of the ACLI's member companies are licensed to do business in West Virginia, and account for 95.4 percent of the life insurance in force in the state. We appreciate the opportunity to comment on the above-captioned proposed regulation, which is of vital concern to our member companies.

The ACLI supports the primary objectives of the proposed regulation, which are, in sum, to prohibit the use of sexual orientation in the underwriting process or in the determination of insurability, to test individuals for the presence of the HIV virus fairly, accurately and with informed consent, and to maintain and disclose test results in a manner that ensures confidentiality. The day-to-day practices of life insurers throughout the country are indicative of the industry's strong commitment to these principles.

There are, however, several aspects of the proposed regulation that are of serious concern to our member companies. Among such provisions are those which would prohibit AIDS testing in connection with group insurance policies, require an applicant to demonstrate an "actual understanding" of the test, prohibit disclosure of test results to the Medical Information Bureau ("MIB") and reinsurers, and prescribe an informed consent form vesting the control of test result disclosure in the applicant. Our comments on these and other concerns, as well as recommendations for changes, are set forth below. Where possible, we propose alternative language that achieves the objectives of the proposed regulation without unnecessarily undermining insurance industry risk assessment procedures.

1001 PENNSYLVANIA AVENUE, N.W.
WASHINGTON, D.C. 20004-2599
202/624-2391
FACSIMILE 202/624-2319

Section 1. General

Comment/Recommendation

There appears to be a typographical error in subsection 1.2, which lists as authority for the regulation West Virginia Code section 16-3C-2(i). The reference should probably be to section 16-3C-2(j), which requires the Insurance Commissioner to develop standards regarding consent for use by insurers which test for the presence of the HIV antibody.

Section 3. Definitions

Comment

There are a number of inconsistencies and ambiguities with respect to the definitions used in the proposed regulation. The definition of AIDS -- "a disease indicative of underlying cellular immunodeficiency" -- is so broadly worded that it could encompass any immune system disorder and not just those disorders associated with the human immunodeficiency virus ("HIV"), the causative agent of AIDS. A definition is given for "Human T-Cell Lymphotrophic Virus (HTLV-III)", yet this term is not used anywhere in the regulation. Finally, a definition is given for the ELISA test but not for the Western Blot test, part of the three-test protocol referenced in subsection 5.7.

AIDS-related terminology has become standardized as the medical community has learned more about the disease. For example, American researchers initially labeled the AIDS virus "HTLV-III", while French researchers labeled it "LAV". The standard definition now recognized by the medical community for the causative agent of AIDS is "HIV", or human immunodeficiency virus. These standard definitions, as a matter of course, have been incorporated into insurance statutes and regulations across the country which govern the AIDS testing and informed consent practices of the insurance industry.

Recommendation

In order to avoid confusion and to conform the proposed regulation with medically-accepted terminology, the ACLI recommends the following definitions:

3.3 "AIDS" shall mean acquired immune deficiency syndrome.

3.4 "ARC" shall mean AIDS-related complex.

3.4 "HIV" shall mean the human immunodeficiency virus identified as the causative agent of AIDS or ARC.

3.5 "Enzyme-Linked Immunosorbent Assay (ELISA)" and "Western Blot" shall mean tests utilized to determine HIV infection.

Section 4. Medical/Lifestyle Applications Questions and Underwriting Guidelines

Comment/Recommendation

Section 4 would incorporate, with some deviations, the Medical/Lifestyle Questions and Underwriting Guidelines adopted by the National Association of Insurance Commissioners in 1987. The ACLI affirmatively supports these Guidelines, which stand for the proposition that sexual orientation should not be a factor in the underwriting process or in the determination of insurability. Therefore, we support section 4 of the proposed regulation.

Section 5. Testing

Subsection 5.1 -- Group Testing Prohibition

Comment

This provision of the proposed regulation would prohibit AIDS testing in connection with group life and health insurance, and would have a severe, adverse impact on insurers writing group insurance in the state. Although most group insurance is currently issued without "individually underwriting" the group participants, there are certain instances where group insurers require participants to furnish evidence of insurability before agreeing to provide group insurance coverage. Such is the case with the underwriting of small groups and late entrants.

Small groups do not in themselves have enough people to allow for sufficient spreading of risk. Therefore, the experience of large numbers of small groups is pooled, and the premiums are set based on the combined experience of all the groups in the pool. As a result, an individual small employer generally will not perceive there to be any direct relationship between the claims experience of his own employees and the premium he pays. From his perspective, if he can get his insurer to pick up sick employees or dependents, it is the insurer's loss. A small employer often knows a good deal about the health status of his employees and dependents, and may not decide to purchase any group benefits for his workers until he becomes aware of impending health care needs. If the insurer is prohibited from having the same level of knowledge as the (employer) applicant does, that will facilitate adverse selection -- i.e., a situation in which a person applying for insurance has knowledge which the insurer does not have that leads the person to expect that the benefits he will receive are likely to exceed the premiums he will pay. In short, this provision would unfairly allow the small

employer to obtain insurance at a price that does not truly reflect the underlying risk.

In order to protect against adverse selection, insurers of small groups generally require the employees and covered dependents of very small employers to submit information about their health before agreeing to insure them. The ability to secure such information is crucial, and restrictions on what medical information insurers may secure will result in group life and health insurance for the small employer becoming both less available and more expensive. This in turn may cause some small employers to decide to cancel their group insurance programs completely.

Group insurers also ask for satisfactory evidence of insurability from late entrants -- people who did not enroll for group insurance benefits when first eligible but who seek to enroll at a later date. If late entrants were not required to submit information on their health status, many people would wait until they knew they had a health problem before applying for group life or health insurance, a classic example of adverse selection. A private insurance program -- be it a large or small employer group -- clearly cannot survive on that basis. A large employer could see his group health insurance plan fall apart quickly if people found out they could simply wait until they were going to need medical care before applying for coverage. Participation in the plan would drop and the average cost per insured would skyrocket, leading to an undesirable situation in which an ever decreasing number of participants are charged ever increasing premiums.

Another instance in which evidence of insurability is required due to the potential for adverse selection involves supplemental group life insurance plans, in which an employer provides employees with a certain amount of group life insurance and then allows them to purchase an additional amount. Since under this type of plan an employee chooses the amount of coverage (which in most cases is a large amount) and pays for the additional amount, insurers typically require health information before agreeing to insure the employee for the supplemental amount. If group insurers were prohibited from testing for AIDS, they would be reluctant to continue writing supplemental life plans, which by their very nature involve an increased risk of adverse selection, resulting in a loss of affordable coverage and a reduction in financial security for many citizens whose only form of coverage may be group life coverage.

Only three jurisdictions -- California, Wisconsin and the District of Columbia -- have ever enacted laws prohibiting insurers from testing for HIV infection. Recognizing that the premises upon which those laws were based are now without foundation, all three legislatures have passed laws authorizing HIV testing by insurers. In fact, no legislature has enacted an HIV test ban applicable to insurers since 1986. In two states, Massachusetts and New York, regulations which would have prohibited AIDS-related

testing of certain insurance applicants were invalidated by the courts (see Life Ins. Ass'n of Mass. v. Comm'r, 530 N.E.2d 168 (Mass. 1988); Health Ins. Ass'n of America v. Corcoran, No. 01-87-ST1078, slip op. (N.Y. Sup. Ct. Albany County Sept. 25, 1987), mod. and aff'd, No. 56959 (N.Y. App. Div. 3d Jud. Dep't Feb. 15, 1990). In both cases, the courts concluded that absent specific statutory authority to do so, the commissioner lacked the implied authority to prohibit AIDS testing by insurers for underwriting purposes.

Recommendation

We feel strongly that this subsection would have a substantial adverse impact on insurers writing group insurance in West Virginia, and could severely affect both the availability and affordability of group insurance, particularly for small employers. For the reasons outlined above, the ACLI firmly believes that insurers must retain the ability to test for AIDS in the underwriting of group life and health insurance. We further respectfully submit that this section goes beyond the scope of authority set forth in Section 1 of the proposed regulation. Moreover, we do not believe any statutory authority exists which authorizes such a restriction on the ability to underwrite for AIDS. Therefore, the ACLI strongly recommends that subsection 5.1 be deleted in its entirety.

Subsection 5.3 -- "Actual Understanding" of the Test

Comment

Subsection 5.3 would require that an applicant demonstrate an "actual understanding" of the test and the testing process. While actual understanding is an admirable goal, it should not be established as the governing legal standard for valid informed consent. Actual understanding is a state of mind known only to the individual involved, and as such it is impossible for a third party to determine with any certainty whether actual understanding exists. It is thus a subjective, rather than objective, standard.

Under this subsection, without actual understanding there would be no valid informed consent. This means that an individual who had signed the consent form could subsequently allege a lack of actual understanding. The insurer could not refute this allegation, because it would not be able to prove a fact that is impossible to prove. The result is that the insurer would be in violation of the regulation. A proposed insured could also argue that the lack of informed consent invalidates the test result. If the test result were positive, the insurer might have to disregard it and issue the policy. If the test were negative and the insurer had issued the policy, the insured might be able to cancel with a full refund of premium, thereby receiving free insurance.

Recommendation

We propose alternative language that achieves the intent of the proposed regulation while at the same time giving necessary protection to insurers which act in good faith. We recommend that subsection 5.3 be revised to read as follows:

> "Such consent shall be based on an understanding by the person to be tested, as evidenced by that person's signature on the informed consent form, that the test is being performed, of the nature of the test, of the persons to whom the results of the test may be disclosed, of the purpose for which test results may be used, and any limitations on the accuracy and meaning of the test results."

Subsection 5.5 -- Designation of Recipient of Test Results

Comment

Subsection 5.5 would vest control of test result disclosure in the applicant, who would have the choice to receive the test results directly. This provision is later contradicted by subsection 5.9, which provides that because news of a positive test result could result in serious emotional trauma, positive results should be communicated to the applicant face to face by a qualified health care professional who could provide AIDS counselling in a more personal setting. We agree that the serious implications of a positive AIDS test result dictate that such information be communicated directly to the applicant by a health care professional, rather than by an insurer who is unqualified to provide such counselling. We also believe that this should be reflected in the informed consent form so as to avoid confusion on the part of the applicant.

Recommendation

We recommend that the language of subsection 5.5 be deleted and substituted by the language appearing in subsection 5.9. Accordingly, we also recommend three corresponding changes to the informed consent form: (1) that the first two sentences of the fourth paragraph of the informed consent form be deleted; (2) that the section of the form which permits the applicant to designate, by initialing a blank line, the person(s) to whom he wishes the test results released be deleted; and (3) the section which permits the designation of a physician or health care provider be retained.

Subsection 5.6 -- Disclosure of Test Results

Comment

Subsection 5.6 would prohibit the disclosure of the fact that an AIDS-related test has been conducted or the results of the test to

any party not designated in the informed consent form, including insurance support organizations such as the MIB, as well as reinsurers. Although the ACLI believes that under current industry practices insurers would not be in violation of this section as it applies to disclosure to the MIB, we feel that this language should be clarified to avoid confusion on the part of insurers who must comply with this requirement and to prevent any misunderstanding on the part of an applicant as to whom test results will be disclosed. Further, we contend that there are compelling business reasons why disclosure to reinsurers, contractors and insurance affiliates must be permitted and can be done in a manner that ensures confidentiality.

Since 1987, positive AIDS test results have been reported to the MIB in the form of a nonspecific, abnormal blood code which includes test results for 22 other diseases or conditions not necessarily related to AIDS (e.g., elevated uric acid, albumin, globulin, total protein). Thus, if Insurer A were to report an abnormal blood code to the MIB, it would neither be reporting the fact that an AIDS test has been conducted nor the results of that test, and as such would not be in violation of this subsection. Moreover, this code can be used only as an alert to Insurer B, which contacts the MIB and requests medical information about the individual, to develop information which it may not have obtained. It cannot be used as a basis for underwriting action pursuant to MIB rules. Therefore, if Insurer B receives a nonspecific abnormal blood code, it must either ignore the MIB report or have the individual tested and act solely on the basis of the results of that test.

To prohibit insurers from reporting the abnormal blood code to the MIB would be to deny all subsequent insurers the opportunity to use the MIB report as an alert to detect attempts by applicants to conceal essential facts about their medical and insurance histories, facilitating the ability of applicants who know they are infected to purchase life insurance at standard premium rates. This was one of the primary considerations that influenced the California, Colorado, Connecticut, Florida, Kentucky, Ohio, New York, Texas and Vermont legislatures to enact laws expressly authorizing reporting of HIV test results to the MIB through the general code procedure.

I have received a copy of the MIB's comments with respect to this proposed regulation that were sent to the Department by letter dated June 25, 1990. These comments address in detail the need for reporting to the MIB, how the MIB meets expectations of confidentiality, and how the MIB is regulated. The ACLI supports the MIB's position, and recommends the incorporation of the language suggested by the MIB into subsection 5.6.

Subsection 5.6 would also prohibit disclosure of test results to reinsurers and, essentially, anyone not so authorized in the

informed consent form. We strongly object to this provision, and feel that there are compelling business reasons why such results should be disclosed, following strict confidentiality procedures, not only to reinsurers, but to an insurer's contractors and affiliates as well.

Insurance companies buy reinsurance to protect themselves from extraordinary or unforeseen losses. For example, a small life insurer might purchase reinsurance on every policy or portion of a policy over $25,000, and a larger insurer may do so on every policy over $100,000. A reinsurer underwrites for risk in the same manner as does the originating insurer, and needs access to all relevant information concerning the risk it is proposing to undertake in order to determine whether to insure the risk and at what cost. Ironically, the effect of a prohibition on disclosure of HIV test results to reinsurers would be to prohibit communications about negative test results. To explain, if an originating insurer receives a positive test result, it would not issue the policy and thus would not need to purchase reinsurance on the policy. Only those originating insurers that have received a negative test result would want to issue the policy and would need to purchase reinsurance. The reinsurer, however, would not accept the risk unless it receives some form of direct assurance from the originating insurer that the individual in question has tested negative for the AIDS virus. Because it would be prohibited access to such information, the reinsurer would have no choice but to decline reinsuring the risk. This in turn could have an adverse impact on smaller insurance companies which, due to their limited capacity, need reinsurance for a greater proportion of their business than do larger insurers.

An insurer's contractors -- persons who provide services to the insurer in connection with the insurance application but who are not employees -- must also be allowed access to test results in the course of the underwriting process. For example, some smaller companies or affiliates of larger companies do not have medical doctors on their own staff. Instead, they contract for the services of an independent outside medical professional or the medical staff of the parent company. Similarly, some small insurers contract their underwriting component to third-party underwriting agencies. The effect of prohibiting disclosure of test results to these entities would be to require smaller companies or affiliates to hire full-time medical personnel and underwriters, something they may not be able to afford to do. Another perhaps unforeseen consequence of prohibiting disclosure of test results concerns insurance affiliates. Suppose a person applied for $100,000 of term insurance from ABC Life Insurance Company. During the processing of the application, however, the person decided that he or she would rather purchase a variable life insurance product. The variable life insurance product is available through ABC's affiliate, XYZ Variable Life Insurance Co. Unless the affiliates of a single insurer are permitted to disclose negative test results to each

other, it would be necessary for the applicant in this example to reapply and go through the whole application process -- including the blood test -- once again.

Life and health insurers already handle a great deal of confidential, sensitive information (e.g., information about psychiatric disorders or alcoholism). The industry has a long history of effectively preserving the confidentiality of such information. Insurers are aware of the highly sensitive nature of HIV test results and have strong business incentives to see that strict confidentiality is maintained. To do otherwise would result in loss of consumer confidence.

Recommendation

In light of the above, the ACLI strongly urges that the Department revise this subsection to permit disclosure of test results to the MIB (through the nonspecific code), to reinsurers, and to contractors and affiliates. Accordingly, the ACLI recommends that subsection 5.6 be revised to read as follows:

> "Insurers shall maintain strict confidentiality regarding medical test results with respect to exposure to HIV or a specific sickness or medical condition derived from such exposure. Information regarding specific test results shall not be disclosed outside the insurance company or its employees, insurance affiliates, contractors or reinsurers, except to the person tested and to persons designated in writing by the person tested. The results of an HIV-related test may be disclosed to the MIB or other insurance support or information sharing organization but only as a brief, coded report and provided that any HIV-related test result disclosed to the MIB or such organization is disclosed as a nonspecific abnormal blood test code. The health care professional performing the test may release the test results to the insurer which requested the test and to such other parties and under such conditions as are dictated by West Virginia Code §§ 16-3C-3 and 16-3C-4."

In keeping with this proposed revision and for consistency purposes, we also recommend that the third paragraph of the proposed informed consent form be revised to read as follows:

> "All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a nonspecific blood test abnormality. If your HIV test

is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you."

Subsection 5.7 -- Testing Protocol

Comment/Recommendation

Subsection 5.7 would establish the testing protocol to be utilized by insurers when testing for the HIV antibody. We recommend two technical changes to this subsection. First, since this subsection applies to the testing procedure and not the application process, the word "questions" in the second sentence of the first paragraph should be changed to the word "testing." Second, in subparagraph (A), the word "immunoasorbent" should be spelled "immunosorbent".

Subsection 5.9 -- Communication of Positive Test Results

Comment/Recommendation

See discussion under subsection 5.5, above.

Informed Consent Form

Comment/Recommendation

We reiterate our recommended changes to the informed consent form set forth in the commentary to subsections 5.5 and 5.6 above.

Comment

The informed consent form contains a sentence which requires the applicant to fill in a date on which the authorization period for the consent form expires. This is problematic in that any arbitrary date could be entered by the applicant (or the agent), or the line could be left blank, which is perhaps more likely to be the case. Specifically referencing a finite time period, such as 90 days, would serve the purposes of informing the applicant of the duration of authorization for the testing to be done and avoiding the inadvertent invalidation of informed consent.

Recommendation

We recommend that the sentence be amended to read "Authorization for consent to test blood, which may include AIDS virus (HIV) antibody/antigen testing, expires 90 days from the date of signature indicated below."

Conclusion

AIDS is one of the most serious health threats the United States has ever faced. As of May 1, 1990 there were 136,204 cases of AIDS reported in the United States, including 83,145 deaths. The Centers for Disease Control reports that there have been 147 diagnosed cases of AIDS in West Virginia. According to federal health officials, by 1994 the disease may have afflicted over 400,000 Americans, causing over 300,000 deaths. Many of these deaths will occur among the 1 million Americans already infected with the AIDS virus, many of whom do not yet show signs of illness.

In the face of mounting numbers of AIDS cases and frightening government projections for the future, life and health insurers have reason to be concerned about insuring those suffering from AIDS and those infected with the AIDS virus. They are also concerned about the impact on current policyholders who may develop AIDS. Insurers will continue to meet their commitments to these people.

While maintaining their commitment to pay benefits for existing policyholders, insurance companies are anxious to insure new policyholders, provided they can be properly classified as to the risk they represent. In order to classify applicants properly, life and health insurers must be able to evaluate the risk of AIDS just as they evaluate the risks posed by diabetes, heart disease, cancer or other medical conditions affecting health and life. Although the industry is fully cognizant of the concerns of those who have been infected with the AIDS virus, it must also consider its responsibility to those who have not been infected.

We appreciate the opportunity to comment on this proposed regulation and hope that these detailed comments are helpful to the Department. Because this proposed regulation is of vital concern to our members, we would be pleased to answer any questions the Department may have concerning our comments and recommendations.

Respectfully submitted,

J. Bruce Ferguson

JBF:pld

Faith
Jerry
Donna
HCC

TELECOPY

Massachusetts Mutual Life Insurance Company
Law Division
(413) 788-8411

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TO: B. Kenneth Huffman

WV Insurance Commissioner Office

304-348-0412

FROM: William Fisher

MassMutual

Number of 4 copies sent including this cover sheet.

If there are any problems with the transmission of this telecopy or if any pages were not received, please call (413) 788-8411, ext. ~~8826~~

July 2, 1990

B. Kenneth Huffman, Esq., General Counsel
Office of the Insurance Commissioner
2019 Washington Street, East
Charleston, WV 25305

Re: Proposed AIDS Regulation

Dear Mr. Huffman:

Our Company has reviewed the above-referenced proposed regulation. While we support regulations governing HIV testing and prohibitions against the use of sexual orientation in the underwriting process, we believe that there are a number of serious problems with the proposed regulation.

Section 5.1 contains a prohibition for AIDS-related testing in connection with group life or accident and sickness insurance. This is a problem for group insurance which is medically underwritten, such as late entrants, supplemental group life coverage, and small group insurance. In each of these situations the risk of anti-selection is as serious as it is for individual insurance. We respectfully submit that this prohibition be eliminated or, in the alternative, that the prohibition extend only to group insurance coverages which are not individually underwritten.

As part of the consent process, Section 5.3 requires that the applicant demonstrate an actual understanding of various items regarding the test, its meaning and disclosure. This is an impossible standard which places the insurance company at great risk. Since a person's understanding is a subjective state of mind, it is inappropriate to attempt to use it as an objective legal standard. At a later date the insurance company could be subjected to liability, because the individual could then claim that he or she neither had an actual understanding nor demonstrated an actual understanding. The ramifications are not clear, but they could range from a violation of the regulation to the inability to use a

positive test result for underwriting purposes. As an alternative to the present language, we respectfully submit the following: "The applicant should demonstrate an understanding, as evidenced by the applicant's signing the consent form, that the test...." It would also be appropriate to include a strong warning immediately above the signature line that the proposed insured should not sign the form, unless he or she fully understands it.

The prohibitions against disclosure contained in Section 5.6 are unduly restrictive. This section and the Appendix A consent form should be modified to permit disclosure to reinsurers, affiliates of the insurer, contractors and the MIB. With respect to reinsurers, it is unrealistic to expect a carrier to reinsure a large risk unless it knows the HIV test result. Disclosure to affiliates should be permitted because within an insurance company holding system, one affiliate often provides the underwriting services to the other affiliates. In addition, disclosure to affiliates is "within the family" and does not constitute an impermissible or offensive disclosure, such as disclosure to an unrelated insurance company without authorization. Many insurers use unaffiliated contractors for underwriting or claim services, and disclosure to these types of entities should be permitted. Finally, prohibiting disclosure to the MIB will only eliminate an important safeguard against insurance fraud. With the current generic blood code reporting of HIV results to the MIB, there are adequate safeguards in place to protect the HIV status of the applicant.

We have several concerns with the provisions of Section 5.7. The word "questions" near the end of the first paragraph appears to be an inappropriate term. Perhaps the intended word was "testing."

Section 5.7 permits a denial of coverage only in the event of a positive test based on the specified protocol. Although the establishment of underwriting standards may be appropriate for legislation, I personally have some question as to whether it is appropriate as a matter of regulation. I am aware of two states, Massachusetts and New York, which have specifically addressed this issue in court decisions. Putting this question aside, the proposed regulation fails from a technical standpoint to address the

question of indeterminate test results. To my knowledge, general industry practice is to postpone an underwriting decision in the case of an indeterminate test result, and to have the applicant retested at a subsequent point in time, perhaps six months later. If the regulation is to establish underwriting standards, it should address the indeterminate test result question in this manner.

We have two concerns with the definitions contained in Section 3. Under Section 3.3, AIDS is defined as "a disease indicative of underlying cellular immuno deficiency." This definition could apply to a number of other diseases unrelated to AIDS, such as leukemia. Our concern is that the regulation could be interpreted as applying the AIDS test and disclosure standards to unrelated diseases. We respectfully submit that the definition simply reference AIDS as being Acquired Immuno Deficiency Syndrome as defined by an appropriate federal agency, such as the CDC.

Section 3.6 references the Human T-Cell Lymphotrophic Virus. I believe that the reference to HLTV III should read HTLV III.

I appreciate this opportunity to submit our comments to you and hope that they will be of assistance in your deliberations. If I can be of further assistance, please let me know.

Sincerely,

William B. Fisher

William B. Fisher
Second Vice President and
Associate General Counsel

WBF:jhb

sMutual

July 2, 1990

ıneth Huffman, Esq., General Counsel
: of the Insurance Commissioner
/ashington Street, East
:ston, WV 25305

'roposed AIDS Regulation

r. Huffman:

mpany has reviewed the above-referenced proposed
tion. While we support regulations governing HIV
g and prohibitions against the use of sexual
ation in the underwriting process, we believe that
are a number of serious problems with the proposed
tion.

ı 5.1 contains a prohibition for AIDS-related testing
nection with group life or accident and sickness
ıce. This is a problem for group insurance which is
Lly underwritten, such as late entrants, supplemental
Life coverage, and small group insurance. In each of
situations the risk of anti-selection is as serious
:s for individual insurance. We respectfully submit
ıis prohibition be eliminated or, in the alternative,
ıe prohibition extend only to group insurance
ies which are not individually underwritten.

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HIAA

Health Insurance Association of America

BY FEDERAL EXPRESS

June 29, 1990

B. Keith Huffman, Esq.
General Counsel
Office of the Insurance Commissioner
2019 Washington Street East
Charleston, WV 25305

RE: Proposed Legislative Rule Chapter 33 Series 27--AIDS Regulation

Dear Mr. Huffman:

I represent the Health Insurance Association of America (HIAA), a trade association of 320 private insurance companies that provide health insurance coverage to over 95 million Americans, including a substantial number of West Virginians. HIAA has serious concerns that proposed Legislative Rule Chapter 33, Series 27, if promulgated, would seriously jeopardize the availability and affordability of health insurance in West Virginia. While we have a number of concerns with the proposed regulation, our most serious concerns are with provisions 5.1, 5.6. and 5.8.

Section 5.1 would prohibit AIDS-related testing for group insurance. The practical effect of that section will be to take away a valuable underwriting tool from insurers, thereby increasing the risk of adverse selection in group insurance. While AIDS-related testing is not typically conducted at this time for large groups, it is an important tool in the small group market and for late entrants into any size group, where there is a considerable risk for adverse selection (i.e., individuals seeking health insurance after learning of a health condition that will likely require treatment). If insurers are not permitted to appropriately underwrite for such circumstances, it will increase the cost of insurance to healthy individuals. If rates increase sufficiently, as is likely based on the high cost of treating AIDS[1], only those individuals likely to need health care will buy

[1]Cumulative lifetime medical care costs of treating all patients diagnosed with AIDS will be $6 billion in 1991. "Confronting AIDS: Directions for Public Health, Health Care, and Research," National Academy of Sciences/Institute of Medicine (1986), 1988 Update.

1025 Connecticut Avenue, NW Washington, DC 20036-3998 202/223-7780 Telecopier 202/223-7897

health insurance. In addition to availability and affordability problems for consumers, such a situation could threaten the solvency of companies faced with a substantial number of AIDS-related claims. We, therefore, believe that Section 5.1 should be deleted from the proposed regulation.

Section 5.6 prohibits insurers from sharing test information with reinsurers or the Medical Information Bureau (MIB), among others. We assume this prohibition stems from the Department's concerns regarding confidentiality. However, the insurance industry has historically received a great deal of confidential or sensitive information in the underwriting and claims handling processes and has demonstrated its ability to maintain the confidentiality of that information.

The inability to share test information with reinsurers will make it difficult--if not impossible--for companies to purchase reinsurance. Such a result would be especially problematic for small companies unable to assume the full risk of a particular block of business. Those companies could lose their ability to compete with larger insurers, and consequently, consumers may have fewer products available to them.

In order to prevent insurance fraud, it is important that companies be permitted to share relevant information with MIB. The MIB was established in 1902 by companies who recognized the substantial financial impact of undetected insurance fraud. Such undetected fraud ultimately hurts the consumer in the form of higher insurance rates. MIB's purpose is to detect and deter fraud and misrepresentation in the underwriting of life and health insurance. To that end, MIB member companies report relevant underwriting results using one or more of numerous codes. Companies may not use MIB information as a basis for determining an applicant's eligibility for insurance. Such information is only used to alert members to the possible need for further investigation. The information is confidential and may only be accessed by member companies under limited circumstances.

It is important to note that AIDS-related test results are reported to MIB in a way that does not identify that an individual has had a positive HIV test result. Such results are reported to MIB only as an abnormal blood test results, using the same code that is used to report abnormal results on a number of other blood tests in addition to AIDS-related tests.

For the reasons stated above, we urge you to amend the proposed regulation to permit the sharing of AIDS-related test results with MIB, reinsurers, contractors and insurance affiliates.

Section 5.8 would require companies to insure individuals with positive HIV test results. It would prohibit an insurer from using a more sophisticated Western Blot test to determine the

validity of equivocal ELISA test results (i.e., where one test result is positive and the other is negative) and require that such individual be treated as though they are uninfected. Such a requirement is directly contrary to the practices of blood banks that use ELISA tests, and in fact, may be considered irresponsible from a public health point of view. We believe that section should be deleted from the proposed regulation.

Although the proposed regulation would permit insurers to ask certain AIDS-related questions, the second sentence of Section 5.7 appears (perhaps inadvertently) to take away their right to use the answers to those questions in making underwriting decisions unless testing is conducted. It seems wasteful to require an insurer to conduct AIDS testing in order to make an underwriting decision if an applicant indicates that he or she had been diagnosed as having AIDS. We recommend that the word "questions" in that sentence be changed to "testing."

In Section 5.3, we do not know how an insurer can ascertain whether the applicant has an "actual understanding" of the items listed. An applicant's signature on an informed consent form should be sufficient. Additionally, we do not understand what is meant by the phrase "any foreseeable risks and benefits resulting from the test."

Section 5.9 recommends that a positive test result be communicated to the applicant by a qualified health care professional. We suggest that this goal can best be achieved through having personal physicians or public health officials convey test results.

With the exception of the third paragraph, the content of the informed consent form is not objectionable. However, we note that the form is rather lengthy (3 pages) and question whether applicants will really take the time to read all that information. In addition, we believe it would be in the best interests of insurers and consumers to use a more standardized form--such as the one developed by the NAIC or the insurance industry. Lastly, while the third paragraph is consistent with Section 5.6 of the proposed regulation, we have recommended changes to that section and, therefore, recommend that the informed consent form be changed accordingly.

Section 4, for the most part, seems to track the NAIC Medical/Life Style Questions and Underwriting Guidelines, which HIAA fully supports. While we have no opposition to the requirements of that section, we note that the example used for Section 4.2 (D) appears inconsistent with the subject of that section. It is difficult to imagine how the symptoms listed could in any way be a proxy for sexual orientation.

Finally, we question whether the West Virginia Code sections listed in Section 1.2 of the proposed regulations provide the

statutory authority needed to promulgate a regulation of this magnitude. Similar regulations in Massachusetts and New York were held invalid because the commissioners lacked specific statutory authority to regulate underwriting practices. See Life Ins. Ass'n of Mass. v. Comm'r, 530 N.E.22d 168 (Mass. 1988) and Health Ins. Ass'n of America v. Corcoran, 154 A.D. 2d 61, 551 N.Y.S. 2d 615 (3rd Dep't 1990).

Thank you for the opportunity to provide these comments. Because HIAA did not learn of the proposed regulations until June 25, our comments are necessarily abbreviated, and we reserve the right to raise additional concerns, as appropriate, during the regulatory and legislative review process. Please feel free to contact me if you would like to discuss this matter further.

Sincerely,

Terri Sorota

Terri Sorota
Senior Counsel
Legal/State Affairs

TLS/kt

cc: Randolph T. Cox, Jr.

7300 Corporate Center Drive
Miami, Florida 33126-1208
MAILING ADDRESS
P.O. Box 020270
Miami, Florida 33102-0270
(305) 470-3100

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LIFE INSURANCE COMPANY

FACSIMILE COVER SHEET

DATE: 7-2-90 (2:10 PM) NO. OF PGES INCLUDING THIS ONE: 4

TO: B. KENNETH HUFFMAN, ESQ. FAX NO. 304-348-0412

COMPANY: WEST VIRGINIA INS. DEPT.

FROM: PATRICIA A. TURNER

JOHN ALDEN LIFE INSURANCE CO. - INDIVIDUAL LIFE DIVISION
P.O. BOX 52-1650, MIAMI, FL. 33152-1650

TELEPHONE: (305) 470-3513 FAX NO.: (305) 470-3542

1-800-327-7012

CH. 33, SERIES 27, AIDS: MESSAGE

ATTACHED WRITTEN COMMENTS ARE BEING TRANSMITTED BY FAX SINCE THE RECEIPT DATE OF THIS PROPOSAL DID NOT ALLOW MAILING TIME.

THANKS

PAT TURNER

PATRICIA A. TURNER, FLMI
Assistant Vice President
Compliance Director
Individual Life Division
(305) 470-3513
Toll Free (800) 327-7012

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P.O. Box 020270
Miami, Florida 33102-0270
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John Alden®
LIFE INSURANCE COMPANY

July 2, 1990

Mr. B. Kenneth Huffman, Esq.
General Counsel
Office of The Insurance Commissioner
2019 Washington Street, East
Charleston, West Virginia 25305

Re: Proposed regulation: Chapter 33, Series 27, AIDS

Dear Mr. Huffman:

We would urge that you extend the comment period on this proposed regulation in view of the fact that the notice was only received here on the east coast on Friday, June 29, and may not yet have been received by some of the west coast companies.

We would also urge a change in Section 6.2 to permit insurance companies to personalize the form by showing their logo/address at the top and then using "we," "us," and "our" rather than the seven references to "the insurer."

We would also encourage you to reconsider the prohibition against reporting information to the MIB since such reporting is already done via the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS. By the same token, your allowing inclusion of test results for the preparation of statistical reports that do not disclose the identity of any particular person would contribute to overall understanding of the scope of this syndrome without in any way infringing upon the confidentiality rights of the person tested.

Finally, we would urge you to set a reasonable time limit for the validity of the consent form, such as 90 days from the date the form is signed, rather than allowing each individual proposed insured to decide how long the authorization period will be.

Your consideration of these comments will be appreciated.

Cordially,

Patricia A. Turner, FLMI
Assistant Vice President

cc: J. Bruce Ferguson
Legislative Director, ACLI
American Council of Life Insurance
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599

VIA FAX

June 20, 1990

AMERICAN COUNCIL OF LIFE INSURANCE
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599

ADVANCE REGULATION SERVICE

WEST VIRGINIA
PROPOSED REGULATION

Attached is a copy of proposed regulation series 27 concerning AIDS.

No hearing has been scheduled. In lieu of a public hearing hearing, written comments may be sent to B. Kenneth Huffman, Esq., General Counsel, Office of the Insurance Commissioner, 2019 Washington Street, East, Charleston, WV 25305. The comment period will end on Monday, July 2, 1990 at 4:30 p.m.

We would appreciate your comments and suggestions. Please send copies of statements filed with the Department to:

J. Bruce Ferguson
Legislative Director
American Council of Life Insurance
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599

Distribution: 39

PLEASE CONSIDER EXTENDING COMMENT PERIOD.

PLEASE CONSIDER ALLOWING THE WE-US-OUR APPROACH AS USED HERE.

John Alden Life Insurance Company
P.O. Box 523850, Miami, Florida 33152-1850

SAMPLE — 1ST PAGE OF ANOTHER STATE'S CONSENT FORM.

John Alden
LIFE INSURANCE COMPANY

HIV TEST INFORMED CONSENT FORM

In order for us to evaluate your eligibility for insurance coverage, we require that you provide a blood sample for testing and analysis. One of the tests that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

TESTING FOR THE HIV VIRUS:

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to the HIV virus are found in the blood of most people with AIDS and AIDS-Related Complex (ARC), and can be found in people who do not have AIDS or ARC but have been exposed to the virus. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

TEST RESULTS:

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at serious risk of developing AIDS or AIDS-related conditions. You may be infected with the HIV virus and infectious to others. You should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result, you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

DISCLOSURE OF TEST RESULTS:

All test results are confidential, except as provided by law. The results of the test will be reported to us by the laboratory. We will not release positive or indeterminate test results except as provided below.

If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider. You may designate another person to receive the result, or you may choose to be notified directly.

Abnormal test results are maintained by our chief underwriter in a separate locked file; they may be disclosed to our medical underwriting staff handling your application and to our affiliates or reinsurers who require the results for medical underwriting purposes. Since abnormal test results are not maintained in our regular insurance files, they are not accessible to other of our employees whose duties do not require access to the results.

If your HIV antibody test is abnormal, a generic code signifying a non-specific blood abnormality will be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record that you have some blood abnormality. If you apply to another MIB member company for life insurance coverage, the MIB, upon request, will supply the information on you in its file to that member company.

PLEASE RECONSIDER

Test results are provided where required by state law or where a court order mandates their disclosure. Finally, test results in rare cases may be made available to our counsel or outside legal counsel in the case of any action brought against us in connection with your application.

We will provide you with the names of the specific individuals or organizations to whom disclosure of your test result has been made if you request this information.

OTHER SOURCES OF INFORMATION:

For more information about AIDS you may call the Virginia Health Department at 1-800-533-4148. The Health Department also makes available personal, face-to-face counseling for those who do not designate another person to receive test results; contact your local health department for information on the availability of such counseling.

CONSENT FOR HIV TESTING:

I have read and I understand this HIV Test Informed Consent Form. I voluntarily consent to the withdrawal of blood, the testing of my blood for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This consent is valid for ninety (90) days from the date of my signature.

PLEASE CONSIDER THIS APPROACH RATHER THAN FILL-IN DATE.

MAILED 7-2 AS CONFIRMATION FOR FAX TRANSMITTAL

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Miami, Florida 33126-1208
MAILING ADDRESS
P.O. Box 020270
Miami, Florida 33102-0270
(305) 470-3100

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LIFE INSURANCE COMPANY

FACSIMILE COVER SHEET

DATE: 7-2-90 (2:10 PM) NO. OF PGES INCLUDING THIS ONE: 4

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COMPANY: WEST VIRGINIA INS. DEPT.

FROM: PATRICIA A. TURNER

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P.O. BOX 52-1650, MIAMI, FL. 33152-1650

TELEPHONE: (305) 470-3513 FAX NO.: (305) 470-3542

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CH. 33, SERIES 27, AIDS: MESSAGE

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THANKS

Pat Turner

PATRICIA A. TURNER, FLMI
Assistant Vice President
Compliance Director
Individual Life Division
(305) 470-3513
Toll Free (800) 327-7012

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(305) 470-3100

John Alden®
LIFE INSURANCE COMPANY

July 2, 1990

Mr. B. Kenneth Huffman, Esq.
General Counsel
Office of The Insurance Commissioner
2019 Washington Street, East
Charleston, West Virginia 25305

Re: Proposed regulation: Chapter 33, Series 27, AIDS

Dear Mr. Huffman:

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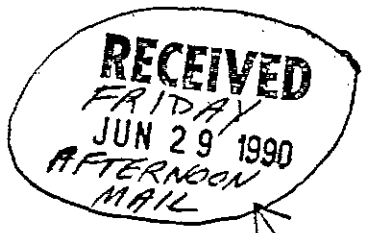
Assistant Vice President

cc: J. Bruce Ferguson
Legislative Director, ACLI
American Council of Life Insurance
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599

VIA FAX



June 20, 1990

AMERICAN COUNCIL OF LIFE INSURANCE
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599

ADVANCE REGULATION SERVICE

WEST VIRGINIA
PROPOSED REGULATION

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LIFE INSURANCE COMPANY

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Abnormal test results are maintained by our chief underwriter in a separate locked file; they may be disclosed to our medical underwriting staff handling your application and to our affiliates or reinsurers who require the results for medical underwriting purposes. Since abnormal test results are not maintained in our regular insurance files, they are not accessible to other of our employees whose duties do not require access to the results.

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PLEASE RECONSIDER

Test results are provided where required by state law or where a court order mandates their disclosure. Finally, test results in rare cases may be made available to our counsel or outside legal counsel in the case of any action brought against us in connection with your application.

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PLEASE CONSIDER THIS APPROACH RATHER THAN FILL-IN DATE.

(White copy to home office. Yellow copy to proposed insured.)

(Virginia only)

MIB, Inc.
(MEDICAL INFORMATION BUREAU)
160 UNIVERSITY AVENUE
WESTWOOD, MASSACHUSETTS 02090
PHONE (617) 329-4500 FAX (617) 329-3379

June 25, 1990

B. Kenneth Huffman, Esq.
General Counsel
Office of the Insurance Commissioner
2019 Washington St., East
Charleston, WV 25305

Re: West Virginia Proposed AIDS Regulation (Leg. Rule 33, Series 27)

Dear Mr. Huffman:

I am writing as I understand that written comments on the proposed regulation are due at your office prior to July 2.

I believe that MIB procedures meet the requirements of the proposed AIDS regulation.

If an insurer receives a positive AIDS-related test from a lab, then the insurer will send a general code to MIB. When insurers report this general code, MIB does not know that the applicant for insurance tested positive for AIDS virus antibodies.

All positive HIV antibody test results are reported to MIB under a general code for nonspecific abnormal blood test results. An MIB member insurance company that subsequently receives a copy of a general code only knows that the general code relates to an abnormal finding in one of 23 tests that are routinely reported under this nonspecific blood test code; see page 12 of the enclosure.

For these reasons, the insurer who reports this general code meets the requirement of Section 5.6 that the insurer "shall not release or disclose either that the test has been conducted or the test results to any other party". Moreover, the insurer who reports this general code meets the requirement of Code 16-3C-3(a) that no insurer "may disclose...the identity of any person upon whom an HIV-related test is performed...".

For the purposes of clarification and to avoid confusion, I respectfully suggest that the proposed AIDS regulation be amended by adding a new sentence to Section 5.6 as follows:

> "The results of an HIV-related test may be disclosed to the MIB but only as a brief, coded report and provided that any HIV-related test result disclosed to the MIB is disclosed as a nonspecific abnormal blood test code."

Amendments of this type have been included in legislation or regulation in at least 17 states so as to validate the MIB general code procedure; see page 14 of the enclosed notes.

I have used the enclosed notes in presentations before state legislative committees and insurance departments. In the notes, I specifically address such issues as why insurers need to be able to report to MIB, how MIB meets expectations of confidentiality and how the MIB is regulated.

I would be pleased to discuss any issues raised by this letter and to answer any questions that you may have about MIB.

Sincerely,

Neil Day

Neil Day
President

ND/sg
D7-30
Enclosure: Notes

copy to: J. Bruce Ferguson at ACLI

MIB, Inc.
(MEDICAL INFORMATION BUREAU)
P.O Box 801
BOSTON, MASSACHUSETTS 02103
TELEPHONE (617-329-4500)

April 24, 1989

Re: Why The MIB General Code Is Not A Surrogate For Seropositivity

MIB strongly believes that its general code for abnormal blood tests is not a surrogate for a positive HIV antibody test for the following reasons.

1. As a statistical matter, insurers cannot assume that an MIB general code is a surrogate for a positive HIV antibody test. Enclosed is a list of the 23 test results reported under the general code for abnormal blood tests; see page 12 of these notes. I would stress the following points. First, only one of the 23 tests refers to HIV testing. Second, actual experience suggests that no more than one of 10 general codes for abnormal blood tests refer to seropositivity; see page 3 of the enclosed notes. Third, our "worst case" assumption is that the ratio might possibly increase to about 30%. However, this assumption is based on unlikely events. A better estimate will require MIB to collect additional statistical data from insurers.

2. As a matter of law, insurers cannot assume that the general code is a surrogate. Such conduct by insurers is prohibited by the NAIC Insurance And Privacy Protection Model Act (NAIC Act) which is the law of at least 11 states. It is my understanding that most insurers respect the NAIC Act in all states where they do business. I would add that the NAIC Act, the Federal FCRA and other laws require that insurers explain the basis for an adverse underwriting decision. For these reasons of law, insurers do not make decisions based solely on an MIB code. For reasons of law and in the interest of sound underwriting, insurers make underwriting decisions based not on MIB codes but on independent underwriting investigations which document medical and nonmedical information.

3. As a matter of MIB requirements, insurers cannot assume that the MIB general code is a surrogate. MIB rules require that MIB codes can only be used as an alert to the possible need for further investigations of an applicant's insurability. This practice is required in the interest of sound underwriting and to avoid unfair competitive practices in the underwriting of risks and the enclosed MIB Rules so state.

Page Two
Why The MIB General Code Is Not A Surrogate For Seropositivity

This requirement is enforced by a very active program of audit visits and self audits; see page 5 of these notes at paragraphs 6 and 7. Such audits demonstrate that this requirement has been respected in all cases as to the general code.

* * * * * * * * * * *

When an insurer receives a triple positive antibody test result (indicating exposure to the HIV AIDS virus) from a lab, then an insurer can submit a code to MIB which has the exact meaning "abnormal blood test for which there is no specific code".

No statute, regulation, bulletin or other law invalidates this MIB general code procedure.

The general code procedure has been validated or reviewed without adverse action as follows:

A. EXPRESSLY VALIDATED BY STATUTE, REGULATION OR INSURANCE DEPARTMENT BULLETIN. (1) Arkansas, (2) California, (3) Florida, (4) Indiana, (5) Iowa, (6) Maine, (7) New Hampshire, (8) New York, (9) Oregon, (10) Texas, (11) Vermont, (12) Wisconsin, (13) Colorado, (14) Utah, (15) Ohio, (16) Virginia, (17) Kentucky.

Of these states, the following seven prescribe informed consent forms which authorize use of the MIB general code procedure. (1) Arkansas, (2) Iowa, (3) Maine, (4) New Hampshire, (5) Oregon, (6) Texas, (7) Vermont.

B. REVIEWED WITHOUT ADVERSE ACTION. (1) Arizona (by 1988 mailings to the insurance department), (2) Hawaii (by regulation proposed in 1987?), (3) Massachusetts (by regulation proposed in 1987), (4) Ohio (met with insurance department in 1988), (5) Office of Technology Assessment - US Congress (OTA-by mailings and discussion in 1988), (6) President's Commission On AIDS (Chair, Admiral Watkins - by mailings and discussions in 1988).

C. SUMMARY.

This means that no adverse action was taken by any legislature, regulator or public representative after its review of the general code procedure.

ND/ed
C15-67

MIB, Inc.
(MEDICAL INFORMATION BUREAU)
160 UNIVERSITY AVENUE
WESTWOOD, MASSACHUSETTS 02090
PHONE (617) 329-4500 FAX (617) 329-3379

March, 1990

NOTES BY NEIL DAY OF MIB, INC.
FOR SUBMISSION TO INSURANCE DEPARTMENTS, LEGISLATIVE COMMITTEES AND STUDY COMMISSIONS

A. INTRODUCTION

The purpose of this submission is to provide detailed information on the following three issues.

- The need for reporting to MIB.
- How MIB meets expectations of confidentiality.
- How MIB is regulated.

B. THE NEED FOR REPORTING TO MIB

The cornerstone of the MIB System for over 80 years has been the code list which is the basis for reports made to MIB by member companies.

Coded reports from MIB serve two functions which are important to present and future policyholders and to insurance regulators and other public representatives.

The first function is that MIB reports serve as an alert to detect attempts by applicants to conceal or misrepresent facts. Using the MIB alert, the member can conduct an underwriting investigation to verify the MIB report.

The second function is to deter omission or misrepresentation. As part of the application process, the applicant is informed in writing about MIB. In this manner, applicants are made aware that information is exchanged by insurers and this awareness serves to deter applicants from concealing or misrepresenting information.

These two functions of MIB reduce losses due to omission or misrepresentation and produce savings which lower premium costs for present and future policyholders.

These two functions have been recognized and validated in numerous regulatory and legislative reviews. For example, the New York State Insurance Department has stated (in 1982) that the MIB goals of detection and deterrence further the regulatory interest of the New York State Insurance Department in the prevention of insurance fraud and misrepresentation.

In 1983, the MIB Board of Directors appointed a Steering Committee of industry experts to fully modernize the 1977 MIB Code List over a two year period.

In late 1985, members of the Steering Committee approved the final form of the 1986 Code List including four objectively defined codes which may relate to AIDS and related conditions and tests.

This new Code List has been in use since March 1986 and it includes four codes which are defined as follows:

1.) The first code has an exact definition which reads as follows: "AIDS related complex or condition (ARC) or acquired immune deficiency syndrome (AIDS)." In 1986, this code was reported 199 times nationwide.

The second, third and fourth codes may or may not relate to AIDS or related conditions and therefore do not use the terms "AIDS or related conditions".

2.) As to the second code, its exact definition is "Unexplained history of any of the following: thrush, other opportunistic infections, weight loss, generalized chronic swelling of lymph nodes, persistent fever or diarrhea." In 1986, this code was reported 231 times.

3.) As to the third code, its exact definition is "Abnormal T Cell study". In 1986, this code was reported 229 times.

4.) As to the fourth code, its exact meaning is "Abnormal blood test for which there is no specific code". In 1986, this code was reported 3,600 times. In 1987, there were 10,000 reports; in 1988, there were 18,000 reports.

Since May, 1987, when an insurer receives a triple positive antibody test result (indicating exposure to the HIV-AIDS virus) from a lab, then the insurer can submit this general code to MIB. When insurers use this general code, MIB does not know that an applicant for insurance tested positive for AIDS virus antibodies.

From March, 1986 until May, 1987, a fifth code was used by insurers but the code was deleted in May, 1987. As to the deleted code, its exact meaning was "Two or more different types of antibody tests indicating exposure to the HTLV-III (AIDS) virus." Until May, 1987, that deleted code was reported about 35 times each month nationwide from the MIB membership of 800 insurers. When insurers used this specific code, MIB knew that an applicant tested positive for AIDS virus antibodies. MIB deleted this specific code so that the insurer's need for MIB information to protect against fraud can be balanced against the applicant's right to confidentiality.

MIB estimates that only 1 of 10 general codes for abnormal blood tests refer to seropositivity for the reasons suggested above. As stated above, 1986 figures show that the specific code on seropositivity was reported about 35 times a month whereas the general code was reported about 360 times each month which is a 10% ratio which may have fluctuated in subsequent years.

Nine of each ten general codes for abnormal blood tests will relate to at least 22 test results not related to seropositivity; see attached listing.

* * * * *

These 4 codes and 200 other codes pertaining to medical conditions or tests may only be reported if the source was the proposed insured or a physician or medical facility contacted with the consent of the proposed insured.

Like any of the codes in the 1986 Code List, these 4 codes are needed to report information to MIB which is significant to health or longevity.

In summary, an insurer needs significant information from MIB and from its own underwriting investigations to minimize adverse financial consequences to present and future policyholders.

C. HOW MIB MEETS EXPECTATIONS OF CONFIDENTIALITY

MIB recognizes that record subjects and public representatives must be satisfied that the MIB System meets substantial expectations of confidentiality.

In the simplest terms, MIB supervises an exchange of underwriting information between its computer facility in Westwood near Boston and its 800 member companies at 1000 locations in the United States and Canada. Each member has a computer terminal to exchange messages with MIB at Westwood.

Each member company must make an annual agreement to protect confidentiality with the following procedures.

1.) The member must use procedures to ensure that only authorized underwriting and claims personnel at the member company have access to MIB reports for permissible purposes. The specific or even general contents of an MIB report are never divulged to agents or brokers as they are not authorized personnel.

2.) MIB reports must be kept in coded form and in secure locations.

3.) The Medical Director or Chief Underwriter must be responsible for limiting access to Code Books to authorized underwriting and claims personnel.

4.) The computer terminal needed for MIB communications must be located, supervised and used in a manner satisfactory to MIB.

5.) MIB reports cannot be requested without the written consent of the record subject which is obtained after the individual reviews a written description of the MIB exchange and correction procedures available to the individual.

6.) The members must annually conduct a self-audit to determine whether its procedures have protected confidentiality of MIB record information and report the results to MIB.

7.) The member shall permit MIB to conduct periodic audits of its confidentiality procedures. At present, each company is audited every third year at the company location by eight experienced underwriting executives who are retained as consultants by MIB for this field audit program. This program was initiated in 1972 and over 4900 field audits have been made. The program confirms that members understand and follow MIB rules including

those which relate to confidential treatment. Willful violations are rare and are promptly remedied as is confirmed by prompt follow-up audits.

A copy of the "General Rules of MIB" is attached and each of these safeguards is required by the General Rules.

In addition to these safeguards used by members, the MIB organization at Westwood uses additional safeguards to protect confidentiality such as the following.

First and foremost, the 1000 terminals that network with the Westwood facility form a system which is very " user unfriendly" and the system has prevented access by unauthorized persons. MIB uses state-of-the-art technology to verify that MIB reports are properly requested and transmitted and all access to MIB is documented. These hi-tech precautions are described in greater detail as follows.

For example, each member terminal has a unique code that identifies that terminal when an inquiry is sent to MIB. The MIB computer will disconnect from the terminal if the identification code is not recognized. In short, the computer will not shake hands with a stranger. In addition, the MIB computer disconnects after it has received inquiries from a company and it dials the company back after the inquiries have been processed. This is unlike "user friendly" systems which do not disconnect but complete all business with a single phone call. Moreover, MIB keeps an exact record of all inquiries sent from each member location and we regularly audit each location to determine that inquiries were only made for appropriate underwriting and claims purposes.

For this and many other reasons the MIB System is not "user-friendly." Hackers have not intruded into the MIB system but

they have occasionally intruded into "user-friendly" systems which link many users with a central data base which has modest provisions for security so as to avoid inconvenience to users.

MIB has a staff of 220 persons at Westwood who are required to maintain confidentiality in many ways including the following.

1.) All are educated as to expectations of confidentiality.

2.) Only a few persons have access to the MIB Code Book.

3.) Physical access to the computer room is strictly limited and access is recorded through a card key system.

4.) Access to the database is also strictly limited by physical means and by software security systems and access is documented.

5.) The computer center is protected 24 hours a day by security guards and by electronic systems (which control access and provides surveillance.)

6.) These and other procedures are the responsibility of our Security Officer and seven key persons who meet monthly to review security procedures.

My final objective is to describe the formal and informal ways in which MIB is regulated.

D. HOW MIB IS REGULATED

My comments have stressed that MIB and its members are committed to self-regulation through written rules and procedures which are enforced through such active methods as frequent audits.

I have also indicated that MIB activities have frequently been reviewed by legislators and regulators and that statement should be amplified at this point.

The New York State Insurance Department published reports on examinations of MIB in 1967 and 1973.

The Federal Privacy Protection Commission published an extensive report in 1976 which summarized a thorough examination of MIB through documents and testimony produced by MIB.

The Federal Trade Commission examined MIB compliance with the Federal Fair Credit Reporting Act. This extensive examination was concluded in 1983 when MIB agreed to be regulated by the FTC and to make minor changes to its disclosure and correction procedures.

In 1986, MIB responded to concerns about confidentiality stated by the Advisory Committee on AIDS formed by the National Association Of Insurance Commissioners. MIB has initiated commitments to meet three concerns identified by the NAIC Committee (which related to subpoenas and confirmation of codes).

In addition to these examinations, MIB has regularly provided documentation and testimony to numerous other federal and state regulators and legislative committees.

Each of the foregoing examinations of MIB confidentiality procedures has confirmed that the MIB system supports an insurer's need for protection against fraud or omission in a manner that is consistent with very substantial standards of confidentiality.

No legislator, regulator or other public representative has documented or even alleged wrongful disclosure of an MIB record.

In a case of wrongful disclosure, the FCRA provides that any MIB employee who gives an MIB report to a unauthorized person shall be fined up to $5,000 or imprisoned for up to one year , or both (see 15 U.S.C. 1681r.) No one has ever asked that any MIB employee be fined.

Additional penalties for wrongful disclosure are stated in the "NAIC Information and Privacy Protection Model Act" which is the law in at least eleven states. Under the NAIC Act, any MIB employee who makes wrongful disclosure could be fined up to $50,000 (section 18). In addition, any person who wrongfully obtains information from MIB could be fined up to $10,000 or imprisoned for up to one year or both (section 22). No one has ever asked for such fines as to MIB records.

E. OVERVIEW

Throughout its history, the MIB system has effectively accomplished its basic purpose. Specifically, MIB helps to detect and deter fraud upon its members and their policyholders by proposed insureds and claimants who may omit or seek to conceal facts essential to accurate, proper and reasonable determination of insurance risks.

MIB's activities have been extensively reviewed by Federal and State legislators and regulators since 1965. Such review confirms that:

- MIB is a reasonable balance between an individual's right to privacy and an insurer's need for protection against fraud or omission.

- The MIB function is consistent with high standards of confidentiality, accuracy, relevancy and utilization of personal information.

F. ENCLOSURES

The items enclosed include:

(1) A model of an MIB report.

(2) Test Results Reported Under General Code For Abnormal Blood Tests.

(3) Why the MIB general code is not a surrogate for seropositivity.

(4) 5 page description of MIB.

(5) The "General Rules of MIB".

MIB, Inc.
(MEDICAL INFORMATION BUREAU)
P.O Box 801
BOSTON, MASSACHUSETTS 02103
TELEPHONE: (617-329-4500)

April, 1987

MODEL OF AN MIB REPORT

The following is a model of a MIB report which I am providing as a representation of the kind of report which MIB member companies receive.

```
WISCONSIN, EDWARD A.
  04JL46 PA
ATTY
N22JA83
  173ZB(551KZB)
N25AG85 508SZC-
  551KZTC-520ZTC
N23JA86 317X
```

This model is typical because the model includes the usual identifiers such as name, birthdate, state of birth, and occupation on the first three lines. Social Security numbers are never included on MIB reports.

The model is also typical in that it includes 3 reports (dated '83, '85, and '86) and a typical number of medical codes. No reports are more than seven years old.

The letter N before each of the 3 reports is another identifier. N indicates residence by a multi-state region such as New England. No street, mail or phone address is ever included.

No report ever identifies the reporting company or the underwriting action it took.

TEST RESULTS REPORTED UNDER GENERAL CODE FOR ABNORMAL BLOOD TEST

12/87

1. Albumin, serum, abnormal (similar to item 19)
2. Amylase, serum, abnormal
3. Bilirubin, serum, abnormal (similar to item 11)
4. Blood test for Syphilis, abnormal
5. BSP Test (bromsulphalein), abnormal
6. Calcium, serum (similar to item 12)
7. CK or CPK (creatine Kinase, creatine phosphkinase), abnormal
8. Coagulation Tests, abnormal
9. ERS (erythrocyte sedimentationrate), abnormal (similar to item 20)
10. HLA - B27, abnormal
11. Hyperbilirubinemia
12. Hypercalcemia
13. Hyperuricemia (similar to item 23)
14. Hypokalemia
15. Latex Fixation test, positive
16. Mean corpuscular hemoglobin (MCH) or volume (MCV), abnormal
17. Phosphate, serum, abnormal (acid)
18. Prolactin, serum, abnormal
19. Protein, serum, abnormal
20. Sedimentation rate, abnormal (ESR)
21. Serum Multichannel analysis (SMA) abnormal
22. Two or more different types of antibody tests indicating exposure to the HTLV-III (AIDS) virus.
23. Uric acid, serum high

MIB, Inc.
Medical Information Bureau, P.O. Box 801, Boston, MA 02103 (617) 329-4500

June, 1990

MIB IN BRIEF

The President of MIB, Inc., Neil Day, briefly describes the Medical Information Bureau (MIB) as follows:

- A report made to MIB in 1986 of heart disease will alert an insurer who receives an application in 1989 that the applicant should admit and describe that history.
- MIB provides an alert to MIB members as to applicants who may omit or attempt to conceal essential facts.
- MIB reports are made by MIB members and are available to an MIB member with the written permission of the applicant.
- MIB reports are not used as the basis for an underwriting decision to reject an application or to increase the cost of insurance.
- Underwriting decisions are based on information from applicants and from medical professionals, hospitals, test labs or other facilities but not on MIB reports.
- MIB supervises the exchange of MIB reports among 750 MIB members who are life insurance companies.
- MIB helps to make sure that all applicants pay her or his fair share of costs for life or health coverage.
- Each member furnishes each applicant with a written description of MIB and its review and correction procedures before an application is completed.
- Any person or his or her medical professional can review or correct information in the person's MIB file.
- Conditions significant to health or longevity such as overweight or hazardous sports are described by 210 medical codes and 5 non-medical codes.
- Readers can contact the MIB Information Office (P. O. Box 105, Essex Station, Boston, MA 02112, 617-426-3660) with questions about MIB or its review and correction procedures.

ND/sg

MIB, Inc.
Medical Information Bureau, P.O. Box 801, Boston, MA 02103 (617) 329-4500

June, 1990

MIB FACT SHEET

INTRODUCTION

The following information is prepared as a concise and current fact sheet which describes MIB, Inc. as of the above date.

MIB IS A NON-PROFIT ASSOCIATION TO PREVENT FRAUD

MIB, Inc., also known as the Medical Information Bureau, is a non-profit incorporated trade association of about 750 life insurance companies formed to conduct a confidential interchange of underwriting information among its members as an alert against fraud. This interchange enables MIB member companies to protect the interests of insurance consumers as well as the interests of life and health insurance providers.

BASIC PURPOSE IS TO REDUCE THE COST OF INSURANCE

MIB was organized in 1902 by physicians who were medical directors of about 15 life insurance companies. These medical directors recognized that their respective companies had lost substantial sums where fraud was not detected. Such losses meant higher premiums which was not fair to the vast majority of policyholders who were honest. What was needed was a system that would protect the honest consumers against higher premium costs which would be necessary if the forgetful or dishonest applicants were too often successful.

MIB's basic purpose was (and continues to be) to detect and deter fraud and misrepresentation in connection with the underwriting of life and health insurance and claims. The elimination or reduction of fraud improves conditions in the life insurance industry in several ways. First, MIB's fraud prevention activities tend to minimize public criticism of the industry, and fosters public confidence by providing assurance that the industry's products are sold in an honest marketplace. Second, by reducing the incidence of risk misclassification, it contributes importantly to the financial soundness of insurance arrangements, in which the entire industry shares an interest. Third, it advances an important public interest in establishing equitable apportionment of insurance costs among policyholders. Finally, it results in cost savings which are passed on to policyholders in the form of reduced premiums and increased policy dividends.

HOW MIB FUNCTIONS TO MEET THE BASIC PURPOSE

Member companies are required to report a brief, coded resume to the MIB of the relevant results of the underwriting evaluation made at the time of application. Medical conditions are reported by using one or more of about 210 codes. Conditions most commonly reported include height and weight, blood pressure, EKG readings, and X-Rays, but only if the condition is significant to health or longevity. Sometimes, non-medical information of a very restricted nature regarding insurability may be reported. Non-medical codes are reported by using one or more of 5 codes. Significant, and therefore reportable, non-medical information includes adverse driving record, hazardous sports and aviation activity as confirmed by the applicant or official records. Member companies may not report information or action as to claims made on life, health and disability insurance.

In the interest of sound underwriting and to avoid unfair competitive practices, MIB coded information may not be used as a basis for establishing an applicant's eligibility for insurance. MIB information is used only to alert members to the possible need for further investigation. An MIB report does not indicate the action that may have been taken in regard to any application for insurance; therefore, an MIB report does not indicate whether an application for insurance is issued, rated or declined. In no case does an MIB report exist unless an insurance application has been made to a member company. All reports more than seven years old are automatically eliminated by computer edit.

MIB MEETS THE EXPECTATION OF CONFIDENTIALITY

All information received by member companies through MIB is held in such manner as will maintain its confidential character. Only member companies may have access to MIB's record information; it is not released to non-member companies or to credit or consumer reporting agencies or to governmental agencies who do not have a court order or authorization from the consumer. In fact, it is released to a member company only after the consumer has signed a written authorization which permits that company to contact MIB as to a current, pending application for coverage requested by the consumer.

AVAILABILITY OF MIB DISCLOSURE AND CORRECTION PROCEDURES

Legislators, regulators and courts have long recognized MIB as a reasonable business institution which must be subject to high standards of accuracy. As part of the application process, the consumer receives a written notice which describes MIB and its function. The notice also states a Boston phone and mail address (Post Office Box 105, Essex Station, Boston, MA 02112 and 617-426-3660) which a consumer may contact in order to obtain a copy of the consumer's MIB record, if any, or to seek a correction to the MIB record. Medical information is disclosed to a medical professional designated by the consumer. Non-medical information is disclosed to the consumer. In an average year, about 7,000 persons request disclosure and about 200 request corrections. These procedures were voluntarily established by MIB in 1971 and were patterned after Federal Law. In 1983,

the Federal Trade Commission and MIB agreed that MIB disclosure and correction procedures would be regulated by the FTC and that a few minor changes would be made to MIB Procedures.

OVERVIEW

Throughout its history, the MIB system has effectively accomplished its basic purpose. Specifically, MIB helps to detect and deter fraud upon its members and their policyholders by proposed insureds and claimants who may omit or seek to conceal facts essential to accurate, proper and reasonable determination of insurance risks.

MIB's activities have been extensively reviewed by Federal and State legislators and regulators since 1965. Such review confirms that MIB is a reasonable balance between an individual's right to privacy and an insurers need for protection against fraud or omission. The MIB function is consistent with high standards of confidentiality, accuracy, relevancy and utilization of personal information.

***

OTHER MIB SYSTEMS

The principal function of MIB, Inc. is the operation of the Medical Information Bureau information exchange as described above. In addition, MIB operates four other systems which collectively represent about 9% of MIB activity.

In 1974, MIB began operating the Alpha Index System for about 30 members. In essence, a subscriber uses the MIB automatic name matching system for location of its own internal records.

In 1980, MIB began operating the DIRS (Disability Insurance Record System) for about 80 subscribers who were concerned about individuals who might overinsure by purchasing disability policies from several insurers.

In 1986, MIB began operating the MIB-TRAN system which is now used by about 650 insurers; this system provides the ability to transmit messages between member companies and other organizations such as laboratories, reinsurers and inspection companies.

Finally, MIB is proud of its role in processing mortality and morbidity studies for the life insurance industry. In 1972, MIB offered MIB staff and computer equipment for use in industry studies which are useful to life insurers and of benefit to the medical profession and general public. The MIB Center for Medico-Actuarial Statistics (The Center) has assisted in three major studies and numerous special studies. Such studies are fully processed by MIB and are based on contributions of data submitted by groups of insurers. Such studies provide current information for purposes such as risk classification and research and the studies are made available to the insurance industry, the medical profession and the general public.

***

- continues next page -

TEXT OF MIB NOTICE

As part of the application process, the consumer receives a written notice which reads substantially as follows:

> Information regarding your insurability will be treated as confidential. XYZ Company, or its reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of it members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.
>
> XYZ Company, or its reinsurer(s), may also release information in its file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

***

TEXT OF AUTHORIZATION

As part of the application process, the consumer signs an authorization which reads substantially as follows:

> "I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the XYZ Life Insurance Company, or its reinsurers, any such information."

***

GENERAL RULES OF MEDICAL INFORMATION BUREAU (MIB, Inc.)

(ADOPTED MAY 25, 1978)

Preamble

MIB, Inc. is a nonprofit Delaware membership corporation whose members are life insurance companies. MIB, Inc. functions under a Certificate of Incorporation and Bylaws adopted in May 1978, which documents sets forth its purposes, membership conditions and governance by a Board of Directors (the Board). When used herein, the term Bylaws includes the collective provisions of said Certificate of Incorporation and Bylaws.

The following rules adopted by the Board pursuant to Article III, Section 1(a), of the Bylaws shall govern the conduct of the business of the MIB.

A. Membership

1. **Pledge**—Each member shall annually execute a Pledge to observe the MIB Bylaws and Rules. The Pledge, in a form prescribed by MIB, shall be executed by the member's Chief Executive Officer, Medical Director and Chief Underwriter.

2. **Correspondence**—Unless another authorized officer has been designated, the home or regional office Medical Director shall be the addressee of all MIB correspondence and will be responsible for bringing MIB correspondence to the attention of authorized company personnel.

3. **Assessments and Charges**—

   (a) Each member shall be annually assessed for its pro rata share of MIB expenses. Each member shall also pay for the MIB information checking service according to the schedule of charges fixed by the Board.

   (b) Within 90 days from the date of notification of admittance to membership, a new member shall contribute its share of the annual assessment and subscribe to the MIB information checking service. Companies admitted after July shall pay one-half of the current year's assessment.

4. **Termination of Membership**—Upon termination of membership by resignation or otherwise, a member shall pay all charges incurred to date of termination.

B. Confidentiality

The exchange of underwriting information among members shall be conducted in a manner that will protect both the confidential nature of such information and the privacy of applicants and insureds.

1. **Confidentiality of Record Information**—All personal information received, stored and transmitted by MIB shall be in coded form to preserve its confidential nature. Each member shall use MIB information **solely** for personal life and health underwriting and claims purposes and for no other purposes. Each member shall adopt procedures for the protection of the privacy of the individuals to whom MIB information pertains.

2. **Confidentiality of MIB Code Books**—

   (a) The Medical Director or Chief Underwriter shall control and supervise the distribution of Code Books supplied by MIB. Each shall be responsible for limiting access to Code Books to authorized medical and underwriting personnel. Each Code Book shall be securely stored in a place of safekeeping and its authorized custodian shall restrict its use to authorized persons.

   (b) The Medical Director or Chief Underwriter shall annually account to MIB for its supply of Code Books and satisfactorily explain any losses.

3. **Confidentiality of Communications**—Each member must submit for MIB approval its operational plan (and any change thereto) for communicating with MIB in a manner designed to preserve the security and confidentiality of such communications, whether by telecommunication, mail or otherwise.

C. Consumer Protective Procedures

1. **Access to Record Information**—Only authorized medical, underwriting and claims personnel of a member shall have access to MIB record information. Each member shall institute internal procedures to prevent the exposure, release or dissemination of MIB information to:

   (a) A company not a member of MIB;

   (b) Any nonmember corporate affiliate of a member;

   (c) Unauthorized personnel of the member;

   (d) Any consumer reporting agency; or

   (e) Any other individual or organization.

2. **Authorization**—No member shall request MIB record information pertaining to any individual without having first obtained that individual's written consent on a form expressly naming MIB as an authorized source. No member shall use any authorization form permitting any organization other than a member to obtain MIB record information.

3. **Pre-Notice**—Each member shall furnish every individual applying for personal life or health insurance with a written pre-notice, in form and language prescribed by the Board, describing MIB, the services it provides to members, and the individual's right to request MIB to arrange disclosure in accordance with procedures set forth in the **Fair Credit Reporting Act.** The pre-notice required by this rule shall be furnished before completion of the application.

4. **Accuracy of Information**—

   (a) Each member shall institute internal procedures to cancel, correct or supplement any report when it discovers or otherwise receives information indicating that such report was inaccurate or incomplete. Any such cancellation, correction, or supplementation shall be made as soon as possible regardless of the time elapsed since the initial report.

   (b) MIB shall be immediately notified whenever a member, after investigation, has reason to believe that a report received from MIB contains inaccurate or incomplete information. Upon such notification, MIB will take appropriate action to determine if any record change is required.

5. **Member Self-Audit**—Each member shall annually, or more frequently when requested by MIB, conduct a Self-Audit to determine whether it has complied with MIB's Bylaws and Rules and whether its internal procedures have protected the privacy of individuals and the confidentiality of MIB record information and Code Books. The results of this Self-Audit shall be reported to MIB on a form prescribed by the MIB.

6. **Field Audit of Member Companies**—

   (a) Each member shall permit MIB to conduct periodic audits of procedures adopted pursuant to these Rules and the member's compliance with such Rules.

   (b) At the member's expense, additional MIB audits may be conducted if any such audit reveals violations.

   (c) Continuing unsatisfactory performance and noncompliance with MIB Rules shall be reported to the Board for action pursuant to Section 4 of Article II of the MIB Bylaws.

D. Administration and Operations

Reporting Underwriting Information to MIB

1. **Conditions for Reporting**—

   (a) No report of underwriting information may be made to MIB unless the MIB requirements for authorization and pre-notice have been met.

   (b) The pre-notice may be printed on the face or back of the investigative consumer report notice required by the **Fair Credit Reporting Act.** If furnished in some other manner, it shall be acknowledged in writing by the applicant. A member may include therein any other notice or information and shall file a copy thereof with the MIB.

2. **Reportable Information**—Underwriting information involving any impairments listed in the MIB Code Book and received by members from original medical or other sources, from official records, or from the applicant during the course of an application for personal life or health insurance must be reported to MIB regardless of the underwriting decision. No report may be made of:

   (a) Amounts of insurance issued or not issued and underwriting and claims decisions; and

   (b) Information received in connection with life, health and disability insurance claims.

3. **Time of Reporting or Changing Reports**—Reportable underwriting information, whether favorable or adverse, must be accurately and completely transmitted (1) within thirty (30) days after a member's receipt of such information or (2) not later than fifteen (15) days after final underwriting decision.

4. **Use of Information—**

   (a) **General Rule**—Any coded information received from MIB shall be used only to **alert** members to the possible need for further investigation of an applicant's insurability. In the interest of sound underwriting and to avoid unfair competitive practices in the underwriting of risks, MIB coded information shall not be used as the basis for establishing an applicant's eligibility for insurance.

   (b) **Exception to General Rule**—Coded medical information received from MIB may be used in considering an applicant's insurability when, **and only when,** the underwriting member can certify that:

      1. Further investigation is not needed to assure that the application being considered and the MIB coded medical information relate to the same person; and

      2. It obtained from the reporting member either:

         (i) the documents (or summaries thereof) which were the basis of the latter's report to MIB, or

         (ii) advice from such member that the MIB coded medical information is verified by information from a medical source or the applicant.

   (c) **Post-Notice**—Whenever MIB coded medical information is used pursuant to Rule D.4(b)2(ii) above, the member shall furnish the applicant with a Post-Notice complying with the Fair Credit Reporting Act and other applicable laws.

5. **Request for MIB Code Details—**

   (a) When underwriting a risk, a member receiving coded MIB information may request MIB to notify the reporting member of its desire to obtain code details, provided, however, that an authorized person of such requesting member can certify that:

      1. A medical examination of the applicant has been completed; or

      2. A statement has been obtained from a medical source; or

      3. In the case of a supplementary code, an investigation of its subject matter has been completed through relevant sources.

   (b) However, details of medical codes may be requested at the same time that the applicant is asked to submit to a medical examination provided that the member can certify that:

      1. The medical source of the coded information has failed to furnish a statement to the requesting member within fifteen (15) working days of the latter's request thereof; or

      2. The applicant represents that the medical source of the coded information is deceased or cannot be identified.

   (c) For these purposes of this rule "medical source" shall mean a licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility.

   (d) A reporting member may decline to furnish details of its reports or to disclose its identity to the requesting member, in which event it shall so notify MIB. The amount and content of information furnished in answer to a request for details shall be within the discretion of the reporting member and any details provided shall not be considered information furnished through the MIB.

(e) Under no circumstances shall the MIB disclose the identity of any originally reporting member company to any member company requesting details.

(f) No member's requests for details submitted through MIB may exceed 15% of that company's reports to MIB.

Comment:

1. Pre-Notice: The form and language of Pre-Notice prescribed by the Board under Rule C(3) is as follows:

   "Information regarding your insurability will be treated as confidential. XYZ Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file."

   "Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachu setts 02112, telephone number (617) 426-3660."

   "XYZ Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted."

2. Authorization: The Authorization should contain substantially the following language:

   "I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the XYZ Life Insurance Company, or its reinsurers, any such information."

   "A photographic copy of this authorization shall be as valid as the original."

3. For detailed discussion of Pre-Notice and Authorization, see MIB circular letters as follows:

Mar.	12, 1974	Major Change in MIB System Pre-Notice and Other Changes	Jul.	2, 1974	Authorization
April	1, 1974	in MIB Procedures	Jul.	3, 1974	Pre-Notice General
May	21, 1974	Pre-Notice and Reinsurance	Sep.	12, 1974	Authorization
May	24, 1974	Pre-Notice and Group	Oct.	16, 1974	Pre-Notice-Mass Marketing
June	4, 1974	Pre-Notice-Agents Bulletin	Nov.	9, 1979	California Authorization Requirements

4. For detailed discussion of other aspects of MIB General Rules, see MIB Circular Letters as follows:

Dec.	29, 1970	FCRA Bulletin No. 1	Oct.	12, 1972	Company Visit Program
Mar.	26, 1971	FCRA and Revised MIB Rules	Jan.	3, 1977	Revised MIB General Rules
Mar.	26, 1971	FCRA Bulletin No. 2	Sep.	30, 1977	Self-Audit
Jun.	30, 1971	FCRA Bulletin No. 3	Dec.	30, 1977	Rule D.4 Revision
Jan.	31, 1972	FCRA Bulletin No. 4			

5. As to section C.1(b) of the General Rules, MIB may, upon request, permit its reports to be transmitted in coded form through a data processing company serving a member which is a nonmember data center, provided that MIB has approved internal procedures maintained by the nonmember and the member which will preserve the security and confidentiality of MIB reports.

GROUP RULES

The use of MIB information in the underwriting of group insurance shall be in accordance with the general rules.

REINSURANCE RULES

1. MIB information may be used in connection with a nonmember's business when there is a reasonable expectation of bona fide life reinsurance, substantial in amount and duration. It may be used by a member in connection with reinsurance which does not include reasonable expection of bona fide life reinsurance, if it is used solely to protect reinsurer's *own* business at risk.

   Comment:

   The MIB provides an exchange of confidential information among its member life insurance companies for their mutual use and protection. By agreement of the members, this is subject to rules as to security and use. It is not in the best interests of the Bureau for reinsurance members to furnish to nonmembers, on a fee basis, the protection derived from this information. However, as a member of the Bureau, the reinsurer has the right to protect its own business at risk and it may use MIB information for this purpose. Whether or not the reinsurer has any business at risk in a particular case, will vary, depending upon the terms of the arrangements with the client company. It is well known that these arrangements differ from reinsurer to reinsurer and even with different clients of one reinsurer. The MIB reinsurance rules are in no sense an effort to seek uniformity in the terms of these arrangements.

   However, certain situations have arisen that do not seem to entail any bona fide reinsurance at risk. For example, we note the following possibilities:

   a. The initial retention period for the reinsured risk is one year or less, or is less than the normal recapture period in the treaty with the nonmember company.

   b. The amount at initial risk is clearly nominal, or is below that normally accepted by the reinsurer in its contract with the nonmember company.

   c. Cases are checked for a small flat fee unrelated to the amount of reinsurance.

   Hereafter, if cases are called to the Board's attention, and these involve any of the above or similar situations, the reinsurer will be asked to demonstrate that it is operating within this rule.

2. Reinsurance companies may not make MIB information available to client companies, member or nonmember.

3. If MIB information is to be used in any situation, the reinsurer must have taken reasonable measures to assure that the inquiring or ceding company shall have in its Home Office a bona fide signed preliminary or regular application for insurance.

4. The Board will furnish to each reinsurer a pledge form which must be executed by an Executive Officer and the Medical Director. This form will provide that:

   a. If MIB information is used in connection with any reinsurance operations, it will be handled strictly in accordance with MIB rules.

   b. The following MIB rules will be carefully reviewed with and adhered to by all nonmember companies with which the reinsurer does business: General Rules A(1), B(1), B(3), C(1), C(2), C(3), D(1), D(2), and D(4) and the Reinsurance Rules.

5. Reinsurance companies shall report impairment information received from nonmember companies and have available sufficient information to make reasonable replies to Requests for Details.

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State Farm Insurance Companies

One State Farm Plaza
Bloomington, Il 61710

William G. Shepherd
Assistant Counsel
Telephone (309) 766-4914

July 2, 1990

Mr. B. Keith Huffman
General Counsel
Office of the Insurance Commissioner
2019 Washington Street, East
Charleston, West Virginia 25305

RE: Proposed AIDS Regulation
(Ch. 33, Series 27)

Dear Mr. Huffman:

This statement is submitted on behalf of the State Farm Insurance Companies ("State Farm"). State Farm Life provides life insurance and State Farm Mutual provides health insurance in West Virginia. The proposed AIDS regulation would severely impact the ability of State Farm to provide efficiently priced insurance products in the life and health area. The proposed regulation appears to pre-date the more recent analysis of the AIDS testing issue. State Farm respectfully suggests that the West Virginia Department of Insurance not adopt the proposed rule and consider the comments and current day business practices of the insurance industry affected by this rule.

First, State Farm supports the general intent of the proposed regulation to the extent that it provides a rational, predictable regulatory scheme that assists the insurer, the consumer, and the regulator to fulfill the intent of the West Virginia state legislature. State Farm believes that there are several areas in the proposed administrative regulation that necessitate comment and suggestions for change. They are as follows:

1. Group Insurance - AIDS Testing Prohibition

The proposed rule in subsection 5.1 prohibits "AIDS-related testing in connection with the application for group life or accident and sickness insurance..." (emphasis added). The prohibition of AIDS testing for group life or group accident or sickness insurance doesn't reflect group insurance underwriting practices. The group insurer must be allowed the opportunity to test for HIV infection. The general prohibition should be changed to allow testing for group insurance policies where the number of individuals insured might be relatively small or where there could be "late entrants" where individual underwriting is required. The underwriting risk and subsequent liability for an insured with

the HIV infection is as important in a group policy as it is in an individual policy. The general prohibition upon HIV testing in group policies should be deleted in its entirety so as to provide the insurer the needed flexibility to underwrite in accordance with the risk.

2. HIV Testing Protocol

The proposed regulation at Section 5.7(c) sets forth a three-step protocol for HIV testing. The third step is the Western Blot blood test which is to "confirm" the two previous ELISA tests. The use of the word "confirms" is not as precise as other language that should be used. The factual situation is that the testing protocol could result in "indeterminate" results; the testing could possibly be done at a time when the person tested is converting to positive status. Insurers must be allowed to decline insurance to someone possessing this risk characteristic. We suggest that the rule be clarified to allow an adverse underwriting decision to be based on an indeterminate Western Blot result.

A related problem is found in Section 5.8; the current standard protocol is that if two out of three ELISA tests are positive, then the Western Blot test is used. The proposed protocol of ELISA and Western Blot where one negative stops the testing is not in line with current protocol.

3. Applicant "Actual Understanding"

The proposed regulation of Section 5.3 requires that the "applicant should demonstrate an actual understanding that the test is being performed..." The insurer should not be required to interpret an applicant's subjective understanding of the test procedure. The directive of the proposed rule is too vague and impossible to enforce. An objective demonstration such as signing the appropriate disclosure form should suffice.

4. Disclosure of HIV Tests Results

Subsection 5.6 of the proposed regulation prohibits the disclosure of the AIDS test results to virtually everyone. Certainly, there are insurance support entities that should know or need to know the test results in the appropriate circumstances. The disclosure prohibition should be clarified and certain identifiable insurance entities should be excepted from the prohibition. First, the Medical Information Bureau should be allowed to receive the generic blood test code as required by its current rule. MIB acts as a clearinghouse or "fraud alert" which serves the useful function of moderating insurance rates. The disclosure should also be allowable when made to reinsurers, insurance affiliates and contractors. For purposes of protecting confidentiality, the disclosure to the MIB and the three entities mentioned above would not detract from that goal. There are numerous instances when the insurer must disclose the result in order to run the business of life or health insurance. Reinsurers must be able to determine that a potential reinsurance risk has received negative HIV

test result. An affiliated insurer has a need to know a HIV test result where applications are made simultaneously to several affiliated insurers; this would prevent the need for multiple testing. The contractor must know the result of a test when the contractor provides services or participates in the underwriting or claims process. The insurance industry is well-acquainted with the need of confidentiality and non-disclosure of sensitive information. It should be allowed the latitude to disclosure test results for appropriate business purposes.

5. Consent Form

The consent form attached as appendix A has certain problems that can be easily resolved. First, the form requires that the statutory Sections 16-3C-3 and 16-3C-4 be attached to the form for the use of the person being tested. This requirement imposes the duty upon an insurer to provide material to an applicant that is commonly available from governmental sources. This requirement goes beyond rules concerning consent to HIV testing and unduly complicates an insurer's business practices. This obligation is made more difficult by the tendency of legislatures to amend statutes making it difficult for insurers to keep the required forms current.

Also, the consent form specifies that blood is to be withdrawn "by needle;" the lancet or "finger prick" method should not be prohibited since it is a medically recognized method of blood withdrawal. We suggest that "by needle" be deleted.

In conclusion, State Farm appreciates the opportunity to comment on this proposed regulation and respectfully requests that revisions of it be made as suggested above.

Sincerely,

William G. Shepherd
Assistant Counsel

WGS/ejc

P.S.: Please note that this letter is being telefaxed on July 2, 1990; the original is being delivered by overnight mail.

Mutual of Omaha Companies

James E. McCabe
Senior Counsel
(402) 978-2633
Telecopy (402) 978-5906

Keith
Jerry
DW
HC

July 2, 1990

Hanley C. Clark
Commissioner of Insurance
2019 Washington St., E.
Charleston, WV 25305

RE: Proposed West Virginia AIDS Regulations

Dear Commissioner Clark:

The proposed West Virginia AIDS Regulation has been reviewed and the following comments are respectfully submitted:

1. Section 5.1 which prohibits AIDS related testing for group life or accident and sickness insurance is objectionable, as anti-selection can be present in group insurance as well as individual insurance.

2. Section 5.3 is ambiguous and needs clarification. The language "The applicant should demonstrate an actual understanding that the test is being performed . . ." establishes a vague standard with no accompanying directives or instructions on what constitutes compliance on the part of the insurer.

3. Section 5.6 should be modified to allow insurers to report test results to the MIB and to reinsurers. Reporting to the MIB would be done pursuant to a generic code as authorized in other state regulations.

4. Section 5.7 needs clarification. Insurers need the right to test for cause so long as the testing is not discriminatory and not based on sex, sexual orientation, age, etc. In addition, the first paragraph of this Section states that "Testing is required to be administered on a non-discriminatory basis for all individuals in the same class . . .". The term "class" is not defined.

5. While we don't disagree with the intent of Section 5.9, this section appears to contradict Section 5.5 which requires that test results be released to the individual unless otherwise designated by the individual.

6. The Notice and Consent form contains a space for the insertion of the date on which the authorization will expire. This sentence should be eliminated from the form. Many problems could arise if such a sentence remains as part of the form. For example, what if no date is inserted? How is the expiration date ascertained?

Respectfully submitted,

James E. McCabe
Senior Counsel

JEM07021.90/sam

Transamerica
Life Companies

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Los Angeles, CA 90015-2211

Law Department

Mailing Address
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Los Angeles, CA 90051-0101

Jerry
Tom
Keith
Dan
Ken
JCC

TELECOPY TRANSMITTAL SHEET

TO: Honorable Hanley C. Clark
Commissioner of Insurance
Department of Insurance

DATE: June 29, 1990

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James M. Jackson
Vice President
and Deputy General Counsel

June 29, 1990

The Honorable Hanley C. Clark
Commissioner of Insurance
Department of Insurance
2019 Washington Street East
Charleston, West Virginia 25305

Re: Proposed HIV
testing regulation

Dear Commissioner Clark:

Our Company has had an opportunity to review the regulation being proposed by West Virginia regarding the underwriting of applicants for HIV infection. I attach a copy of an internal memorandum citing some of the difficulties we see with the proposal in its current form. In addition to writing you in my capacity with Transamerica Occidental Life, I am Chair of an ACLI subgroup on AIDS Regulation and speak for that group as well.

Many of the provisions of the proposal seem to hark back to an earlier point in the development of these regulations. As I'm sure you are aware, Commissioner, both the proponents of banning all testing by insurers and the opponents of such a position, namely the life and health insurance industry, have had many encounters, confrontations and negotiations on these issues over the past five years. The result has been the development of certain workable requirements on insurers which are acceptable to the proponents of total ban or tight restrictions, as well as the life and health insurance industry.

I would respectfully suggest that the current proposal be withdrawn and a new suggestion substituted therefor. I believe one of the turning points in cooperation among the affected parties took place in the California legislature when our HIV testing protocol law was passed. Believe me, both sides worked long and hard to arrive at the conclusions contained in that testing bill. It has worked well for both sides since its enactment. It could serve as a useful starting point for a new regulatory proposal in West Virginia. To so utilize it would have the added advantage of working with a system which insurers are used to, from an administrative standpoint. Using also the NAIC's Guidelines for HIV testing might also be useful to your staff in considering this issue.

Thank you for the opportunity of presenting these views. I urge you to consider withdrawing the current proposal and substituting a more updated, forged in open debate and controversy measure, such as the one in California, as a new starting point. We would be pleased to work with your staff on any further refinements of these proposals, to the extent we might be helpful to you.

Very truly yours,

James M. Jackson

TRANSAMERICA
LIFE COMPANIES

INTEROFFICE CORRESPONDENCE

From: Research & Communications

Date: June 28, 1990

To: Jim Jackson

Subject: West Virginia Proposed Regulation

There are a few difficulties with the draft.

1. Section 5 Testing
   5.7 "An insured may not be denied coverage on the basis of AIDS related questions unless a positive AIDS test under prescribed protocol is obtained and is positive.

   If the person answered yes to a diagnosis of AIDS on the application question, and if we tried to obtain the HIV test result from a physician and could not obtain or if we could not verify the testing protocol, we would have to issue standard. Otherwise we would need to order our own HIV test. If, for whatever reason, our initial ELISA was negative, we could not decline or rate but we would have to issue on a standard basis.

2. Section 5 Testing
   5.7 "If <u>any</u> of the test results in the ELISA-ELISA-Western Blot series produce a negative result, the testing ceases and the applicant cannot be denied coverage based on AIDS-related concerns.

   <u>This is not the normal test protocol.</u> Normally, if the first test is positive and the second test is negative, a third test is performed. If that is negative, it is reported as negative. If it is positive, a Western Blot is performed. If the WB is negative, the whole test series is reported as negative.

3. Consent Form
   Delete "by needle" a/c Dried Blood Spot.

4. See 5.6 and 4th paragraph of consent form. Who is the health care professional who performs the test? Is it the insurer? Is it the person who drew the blood specimen? Is it the laboratory? This does not really make sense in the insurance context. It really seems to appropriately apply to the health care professional that we release our result to. We are certainly under no obligation to report to the CDC, partners, or any of the others, are we? This must be clarified as additionally it most certainly gives a confusing and wrong impression on the consent form.

5. Regarding Diana's comments, I agree this appears to be a problem.

MIB - the test results are not released, but a generic code for abnormal blood test result is entered. Can we do this coding?

Reinsurers - It is imperative that these test results be released to reinsurers. In practice, this is only negative results. HIV testing is a routine requirement for reinsurers (at various ages and amounts) who accept business either automatically or facultatively.

This proposed regulation does need some revising.

Jean Sater

cc: D. Marchesi
T. Burgoyne
R. Colligan
Dr. Kleinsasser

CNA INSURANCE COMPANIES

CNA Plaza, Chicago, Illinois 60685

Approved by: James R. Lafuse

FAX TRANSMISSION INSTRUCTION

Date: July 2, 1990

PLEASE DELIVER THE FOLLOWING PAGES TO:

Name: B. Keith Huffman, Esq.
Company/Firm: General Counsel
Office of the Insurance Commissioner
Location: 2019 Washington Street, East
Charleston, West Virginia 25305
Phone Number: (304) 348-3354
FAX Number: (304) 348-0412

From: Catherine M. Kamrow (Mrs.)
Phone Number: (312) 822-5154
Floor: 43S
Re: WEST VIRGINIA INSURANCE COMMISSIONER'S PROPOSED AIDS REGULATIONS CHAPTER 33 SERIES NO. 27

Number of pages (excluding cover page): 2

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CNA Plaza, Chicago, Illinois 60685

July 2, 1990

B. Keith Huffman, Esq.
General Counsel
Office of the Insurance Commissioner
2019 Washington Street, East
Charleston, West Virginia 25305

Re: West Virginia Insurance Commissioner's Proposed
AIDS Regulations Chapter 33 Series No. 27

Dear Mr. Huffman:

Please accept these written comments in regard to your Agency's proposed AIDS regulations on behalf of the CNA Insurance Companies including Continental Assurance Company, Continental Casualty Company and Valley Forge Life Insurance Company.

CNA fully supports the NAIC Medical/Lifestyle Questions and Underwriting Guidelines affecting AIDS and ARC as well as reasonable AIDS-related laws and regulations concerning consent and disclosure of AIDS-related tests for insurance purposes. There are several areas of major concern with respect to the proposed regulations, however, on which we wish to comment.

Section 5.1 would prohibit AIDS-related testing in connection with all group life or accident and sickness insurance applications. With respect to large groups, it is not customary to require testing or other evidence of insurability at initial enrollment for routine amounts of insurance. Nevertheless, in order to reduce the risk of selection against insurance companies, and especially in connection with small groups which do not present statistically reliable experience, certain situations call for reviewing and obtaining medical information including AIDS-related testing. The reason for such exceptions is to prevent anti-selection from individuals who have developed health histories and to prevent an undue increase in claims experience which would have the effect of increasing costs to the group plan as a whole while unfairly burdening other plan participants. We recommend that such testing be permitted with respect to the following:

1. An individual who seeks to become a member of an insured group after having declined a previous offer of coverage under the group policy;

2. An individual who seeks life insurance coverage under a group policy in excess of the maximum coverage available under the policy without evidence of insurabillity;

3. A group policy covering less than 25 individuals or issued to a multiple employer trust.

The restrictions under Section 5.6 regarding disclosure of test results to reinsurers and the reporting to MIB, Inc., are of great concern. An insurer must be able to disclose test results to its affiliates, reinsurers and its employees to whom disclosure is often routinely necessary in the ordinary course of business. Reinsurers rely on the review of underwriting files by the ceding company (like CNA) in order to make their underwriting evaluations. Both companies, reinsurer and ceding, share the risk and prohibiting the reinsurer from access to that information could adversely affect reinsurance costs and availability. With respect to MIB, Inc., we do not object to a prohibition of sending actual AIDS-related test results. We do believe however, that CNA and other insurers should be able to report to MIB, Inc., under a generic code which is not restricted to AIDS-related test results but which signifies only a non specific blood test abnormality and does not indicate the applicant was tested for HIV infection. This prevents anti-selection and the potential for fraud which can lead to higher rates. The currently used procedure which we have recommended is a cost effective way to provide information while protecting the confidential nature of that information.

We believe the essence of Section 5.9 is important and should be recommended to the applicant directly. We thus suggest it be included in the Consent Form itself. On the other hand, we believe that an insurance company should not have to release test results to the applicant in addition to a named health care professional as this would tend to defeat the purpose of naming a professional in the first place. We believe the Consent Form should permit the applicant to request disclosure either to him or herself or to a health care professional, but greatly encourage the latter.

The Notice and Consent Form appearing in Appendix A calls for the name and address of the examiner. It is general practice to have the agent procure informed consent from all applicants at the time of the application. HIV tests ultimately may or may not be ordered depending upon our underwriting rules which are non-discriminatory and based on such things as age, amount of insurance applied for and medical history. This data is not known when the agent takes the application and CNA normally does not know which individual or facility will draw blood if such is necessary. We thus recommend that this item be deleted from the form.

In conclusion, we wish to stress our agreement with the basic objectives of the proposed regulations but feel that the changes suggested are necessary and desirable.

Very truly yours,

Catherine M. Kamrow

Catherine M. Kamrow (Mrs.)
Counsel
Law Department - 43S
(312) 822-5154

CMK:gb

CNA INSURANCE COMPANIES

CNA Plaza, Chicago, Illinois 60685

July 2, 1990

B. Keith Huffman, Esq.
General Counsel
Office of the Insurance Commissioner
2019 Washington Street, East
Charleston, West Virginia 25305

Re: West Virginia Insurance Commissioner's Proposed AIDS Regulations Chapter 33 Series No. 27

Dear Mr. Huffman:

Please accept these written comments in regard to your Agency's proposed AIDS regulations on behalf of the CNA Insurance Companies including Continental Assurance Company, Continental Casualty Company and Valley Forge Life Insurance Company.

CNA fully supports the NAIC Medical/Lifestyle Questions and Underwriting Guidelines affecting AIDS and ARC as well as reasonable AIDS-related laws and regulations concerning consent and disclosure of AIDS-related tests for insurance purposes. There are several areas of major concern with respect to the proposed regulations, however, on which we wish to comment.

Section 5.1 would prohibit AIDS-related testing in connection with all group life or accident and sickness insurance applications. With respect to large groups, it is not customary to require testing or other evidence of insurability at initial enrollment for routine amounts of insurance. Nevertheless, in order to reduce the risk of selection against insurance companies, and especially in connection with small groups which do not present statistically reliable experience, certain situations call for reviewing and obtaining medical information including AIDS-related testing. The reason for such exceptions is to prevent anti-selection from individuals who have developed health histories and to prevent an undue increase in claims experience which would have the effect of increasing costs to the group plan as a whole while unfairly burdening other plan participants. We recommend that such testing be permitted with respect to the following:

1. An individual who seeks to become a member of an insured group after having declined a previous offer of coverage under the group policy;

2. An individual who seeks life insurance coverage under a group policy in excess of the maximum coverage available under the policy without evidence of insurabillity;

3. A group policy covering less than 25 individuals or issued to a multiple employer trust.

The restrictions under Section 5.6 regarding disclosure of test results to reinsurers and the reporting to MIB, Inc., are of great concern. An insurer must be able to disclose test results to its affiliates, reinsurers and its employees to whom disclosure is often routinely necessary in the ordinary course of business. Reinsurers rely on the review of underwriting files by the ceding company (like CNA) in order to make their underwriting evaluations. Both companies, reinsurer and ceding, share the risk and prohibiting the reinsurer from access to that information could adversely affect reinsurance costs and availability. With respect to MIB, Inc., we do not object to a prohibition of sending actual AIDS-related test results. We do believe however, that CNA and other insurers should be able to report to MIB, Inc., under a generic code which is not restricted to AIDS-related test results but which signifies only a non specific blood test abnormality and does not indicate the applicant was tested for HIV infection. This prevents anti-selection and the potential for fraud which can lead to higher rates. The currently used procedure which we have recommended is a cost effective way to provide information while protecting the confidential nature of that information.

We believe the essence of Section 5.9 is important and should be recommended to the applicant directly. We thus suggest it be included in the Consent Form itself. On the other hand, we believe that an insurance company should not have to release test results to the applicant in addition to a named health care professional as this would tend to defeat the purpose of naming a professional in the first place. We believe the Consent Form should permit the applicant to request disclosure either to him or herself or to a health care professional, but greatly encourage the latter.

The Notice and Consent Form appearing in Appendix A calls for the name and address of the examiner. It is general practice to have the agent procure informed consent from all applicants at the time of the application. HIV tests ultimately may or may not be ordered depending upon our underwriting rules which are non-discriminatory and based on such things as age, amount of insurance applied for and medical history. This data is not known when the agent takes the application and CNA normally does not know which individual or facility will draw blood if such is necessary. We thus recommend that this item be deleted from the form.

In conclusion, we wish to stress our agreement with the basic objectives of the proposed regulations but feel that the changes suggested are necessary and desirable.

Very truly yours,

Catherine M. Kamrow

Catherine M. Kamrow (Mrs.)
Counsel
Law Department - 43S
(312) 822-5154

CMK:gb

LINCOLN NATIONAL CORPORATION

FAX MESSAGE

DATE July 2, 1990

TO: NAME The Honorable Hanley C. Clark
COMPANY West Virginia Dept. of Insurance
ADDRESS _____ PHONE 304/348-3354

FACSIMILE TELEPHONE NUMBER 304/348-0412

NUMBER OF PAGES -3- (including cover)

FROM FACSIMILE TELEPHONE NUMBER (219) 427-7627
LINCOLN NATIONAL CORPORATION
FORT WAYNE, INDIANA

SENDER NAME: Marcia Horton

DEPARTMENT: Government Relations

PHONE #: 219/455-2128

Marcia L. Horton
Second Vice President
Governmental Relations

1300 South Clinton Street
P.O. Box 1110
Fort Wayne, Indiana 46801
219-427-2128

LINCOLN NATIONAL CORPORATION

July 2, 1990

The Honorable Hanley C. Clark
Commissioner of Insurance
West Virginia Department of Insurance
2019 Washington Street East
Charleston, West Virginia

Re: Proposed Regulation Series 27 Concerning AIDS

Dear Commissioner Clark:

I am writing on behalf of Lincoln National Life Insurance Company with our comments regarding your Department's Proposed Regulation Series 27 Concerning AIDS.

When AIDS came to the attention of the public and issues related to insurer underwriting practices were raised, Lincoln National with other members of our industry worked diligently with the NAIC and representatives of public interest groups to develop AIDS underwriting guidelines. So we are pleased that your Department has developed a proposal for underwriting guidelines and informed consent. However, we oppose several provisions in your Proposed Regulation Series 27 because they go further than protecting HIV infected applicants from insurer discrimination...they in fact give HIV infected applicants an unfair advantage over applicants with other medical conditions which render them uninsurable. And, they could jeopardize an insurer's financial condition because the Proposal calls for imprudent deviation from sound medical underwriting practices.

First, we strongly object Section 6.B which specifically prohibits an insurer from sharing an applicant's test results with its reinsurer or the MIB. An insurer routinely shares other types of medical information with its reinsurer and the MIB as part of the normal underwriting process.

Reinsurers, like Lincoln National, need access to underwriting information so that they can evaluate the risk they are assuming from the ceding insurer. Reinsurer access to test results of a ceding insurer's applicant is consistent with the insurer's right to test and to underwrite the original risk. If a reinsurer is prohibited from gaining access to relevant medical information which is known by the ceding insurer, a ceding insurer could "select against" the reinsurer knowing that it could minimize its risk by passing the risk to its unsuspecting reinsurer. This could pose severe financial consequences for the reinsurer which would be unaware of the uninsurable risk it was assuming. A reinsurer could protect itself only by terminating its agreements with regard to business written in states where it was legally denied access to relevant underwriting information.

This potential reduction in reinsurance capacity is clearly not in the interest of the consuming public.

With regard to the MIB, we believe the proposed prohibition on the release of test results not only runs counter to the purpose of the MIB but could also increase the cost of insurance for the insurance consuming public. The MIB was established to (1) prevent fraud and misrepresentation by insurance applicants who seek policies by moving from one company to another and to (2) deter fraudulent applications since each applicant is advised that the information or diagnosis in the medical report will be furnished to MIB. Under the MIB's rules, an insurer cannot make an underwriting decision solely on the basis of MIB information, and an MIB code can be used only as an alert. Also, HIV test results are reported to the MIB by way of a generic code which includes other blood abnormalities. Therefore, an insurer would have now way of knowing whether an applicant's MIB code for blood abnormalities was related to a positive HIV test or some other test. Finally, every other state which has considered prohibiting the sharing of HIV test results with the MIB, and with reinsurers, has concluded after examining the facts that the prohibition was unnecessary.

We also object to Section 5.1 which prohibits AIDS related testing in connection with the application for group life and health insurance. This prohibition gives HIV infected individuals a preferential status over other applicants for group life and health insurance who have other medically uninsurable conditions such as cancer and forces an insurer to guarantee issue on a discriminatory basis. Furthermore, it increases the likelihood that adverse selection will occur,particularly in the case of late enrollees. By essentially forcing insurers to provide group coverage to HIV infected individuals, your Department's proposal could lead to higher insurance costs for employers and their employees.

In conclusion we urge your Department to amend your proposed regulation to (1) permit HIV testing in connection with group life and health insurance; (2) permit sharing of HIV test results with reinsurers and the MIB; and (3) to modify the proposed informed consent form to reflect the changes in the regulation.

We appreciate the opportunity to submit comments. You may call me at (219) 455-2128 if you would like additional information about the points we have raised.

Sincerely,

Marcia L. Horton

Marcia L. Horton

cc: J. Bruce Ferguson, ACLI

Aetna

Law Department
151 Farmington Avenue
Hartford, CT 06156

Richard D. Broome
Counsel
(203) 273-0343

July 2, 1990

Hanley O. Clark
Insurance Commissioner
State of West Virginia
2019 Washington Street, East,
Charleston, WV 25305

RE: AIDS TESTING REGULATION ; TITLE 33 SERIES 27

Dear Commissioner Clark:

The following are comments of Aetna Life Insurance Company and Aetna Life Insurance and Annuity Company (Aetna) pertaining to the AIDS testing and underwriting regulation (Title 33, Series 27) and we respectfully request that the comments become part of the permanent record in this proceeding.

Aetna believes that the regulation does not appropriately balance the legitimate privacy interests of health and life insurance applicants and the interests of insurers to properly underwrite individual and group risks. This inbalance is likely to result in adverse experience which negatively impacts all West Virginians who wish to purchase life insurance and unnecessarily and unfairly increase health insurance costs for employers and individuals.

The following are sections that should be revised or deleted to strike an appropriate balance between individual privacy concerns and those of a population forced with spiralling health care costs.

- Sec 5.1 The ban on testing in the group context should be eliminated from the final rules. It will be particularly difficult to accurately underwrite small groups without the flexibility to conduct AIDS tests. Employers in the small group market could suffer large premium increases due to experience if screening is not permitted.

- Sec 5.3 The term "actual understanding" is confusing and should either the term should be stricken or it should be defined so that written consent constitutes "actual understanding".

We believe that Sec 5.2 which requires written consent is the correct standard and it is appropriate to wonder what will constitute "actual understanding" if it is something in addition to written, informed consent.

- Sec 5.5 The applicant should not have sole discretion to disclose test results. This provision will likely result in costly, multiple testing that serves neither the applicant nor the public at large.

- Sec 5.6 The prohibition against disclosure to MIB is unwarranted. Specific Safeguards have been constructed at the Bureau so that positive HIV test result will be indistinguishable from a number of other blood disorders. Applicants' privacy will be protected without resorting to the extreme position of an outright reporting provision. Rather, other regulations have appropriately required that only a certain percentage of HIV results be grouped with other blood disorders in a particular category so that HIV test results cannot be matched to particular applicants. We respectfully request that this prohibition be deleted from the final draft.

Sincerely,

Richard D. Broome
Counsel

RDB/ma

cc: M. O. Campbell
J. C. Lobert

AETNA LIFE & CASUALTY
151 FARMINGTON AVENUE
HARTFORD, CONNECTICUT 06156

LAW DEPARTMENT

TELECOPIER COVER PAGE

DATE: July 2, 1990

TO: Hanley Clark

FROM: RICHARD D. BROOME, COUNSEL

Number of Pages Including This Cover Page: 3

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HARVEY W. POGORILER
Assistant General Counsel

Northwestern Mutual Life

June 26, 1990

RECEIVED
JUL 2 1990
LEGAL DIVISION
W. VA. INS. DEPT.

B. Kenneth Huffman, Esq.
General Counsel
Office of the Insurance Commissioner
2019 Washington Street, East
Charleston, WV 25305

Re: Proposed AIDS Regulation (Chapter 33 Series 27)

Dear Mr. Huffman:

We have received a copy of the regulation proposed by the Department regarding various AIDS matters. We understand that no hearing has been scheduled on the regulation, but that written comments would be acceptable to the Department. Accordingly, we offer the following written comments for your review and consideration.

Before commenting on the individual sections of the proposed regulation, we would note initially that under W. V. Stats. § 16-3C-2(j), the Commissioner of Insurance is to develop standards regarding consent for use by insurers which test for the presence of HIV antibody. While it would be premature to dispute the matter of the Commissioner's authority to promulgate this regulation at this early stage of the proceedings, we do find it a matter of great concern that the Commissioner proposes to go so extensively into many areas beyond that described in the statute; moreover, as further described below, we feel that the Commissioner proposes to establish standards that could cause unreasonable losses to insurers and unfair and discriminatory treatment of policyholders in the state.

The following comments relate to specific sections of the regulation:

Section 3.3. The definition of AIDS is much too broad, since it could cover many sorts of immunodeficiency conditions apart from AIDS. My research indicates that AIDS is often not defined in statutes and regulations dealing with AIDS testing, but if you feel it is necessary to set out a definition, you might borrow one of the type that is used in some statutes and regulations, such as that found in N. Y. Stats. Art. 27-F, § 2780(1) ("'AIDS' means Acquired Immunodeficiency Syndrome, as may be defined from time to time by the Centers for Disease Control of the United States Public Health Service").

Section 3.4. I thought the definition of AIDS-Related Complex (ARC) was not too easy to follow, and I had hoped to offer a substitute. However, my research indicates that AIDS-Related Complex seems to be a disappearing, obsolete term in the AIDS field. The current view seems to be that HIV infection is a progressive disease, which, in its final and terminal phase, is called AIDS; however, beyond that, medical people have stopped using the term AIDS-Related Complex, and many of the statutes and regulations I looked at simply do not use the term anymore. Where the term is used, as in W. V. Stats. § 16-3C-1(c), the technique is simply to advise that the acronym ARC means AIDS-Related Complex, but there is no attempt to further define the term.

Section 3.5. This definition, too, is rather outdated. We would suggest using the definition set out in § 16-3C-1(f), that is, "'HIV' means the human immunodeficiency virus identified as the causative agent of AIDS."

Section 3.6. What is set out here as "HLTV III" (actually, HTLV III is meant) is now an obsolete term for HIV. In addition, we note that HTLV III is not used anywhere else in the regulation. Accordingly, Section 3.6 should be deleted.

Section 3.7. The more customary way of setting out this term is to merely define the acronym, ELISA, as Enzyme Linked Immunosorbent Assay. (Note, incidentally, the spelling of "Immunosorbent," rather than "Immunoasorbent."

Section 4.2(C). We have some difficulty with the limitations set out here. While we would understand a limitation on underwriting based on the mere taking of a prior HIV test, regardless of the actual results of the test, we disagree with the limitation on asking whether a test has been taken (as opposed to asking whether the person has tested positive on the test). Individuals will sometimes know they have been tested, but they will not recall what the test results were, or they will recall incorrectly, or they may become confused about whether the test results were positive or negative (this is because "positive" carries a favorable connotation, notwithstanding that a "positive" HIV antibody test actually means that the person has been infected). Other states have faced this same issue, and we would suggest that their lead be followed by revising this subsection to permit insurers to ask generally about prior HIV tests, subject to a limitation on the use by the underwriter of the test results as the sole basis on which to deny coverage--that is, the test results may be used as the basis for a declination only if positive and if the ELISA/ELISA/Western blot protocol was followed.

Section 4.2(H). The sentence which appears at the end of subsection (I) (that is, "This subsection does not apply to an applicant seeking treatment and/or diagnosis.") should also appear at the end of subsection (H).

Section 5.1. A prohibition on testing in the group insurance area will not have a particularly direct effect on Northwestern Mutual Life; however, we strongly object to any prohibition on such an effective and important underwriting tool as testing for HIV infection. Given the extremely high reliability of the current HIV test protocol and the requirements that now exist as to informed consent and confidentiality, it would be a major step backward to establish those infected with HIV as a protected class for insurance purposes, thereby making all other insureds (including those with other life or health threatening conditions) subsidize them. Perhaps the legislature of your state, after a full consideration of all the issues, could determine that as a matter of public policy it should impose such a system of subsidies; it is the rare legislature that has done so, however.

Section 5.3. We strongly object to the notion stated here that an applicant "should demonstrate an actual understanding" of various items related to the HIV test. It is simply impossible as a practical matter for the person administering the test to determine the subjective understanding of another person on these various items. The best that can be done is to require a notice and consent form which sets out the various items discussed in this section, and to prohibit testing except that which follows the obtaining of the signature of the person to be tested, or that person's parent or guardian.

Section 5.5. We do not object to the individual's having, prior to the administration of the test, the opportunity to designate another person to receive the test results, but we would object to any suggestion that the designation must be made prior to the administration of the test. This conflicts with sound practice in this area, and it even would conflict with section 5.9 of the same regulation, where it is recommended that positive results be communicated to the applicant face-to-face by a qualified health care professional who could provide AIDS counseling. (See, also, the draft consent form.) I should note that at Northwestern, we always attempt to obtain the name of a health care professional if we receive a positive test result, and if the proposed insured has not designated one on the consent form, we seek to obtain the designation after we have received the positive result.

Section 5.6. We think this section not only contradicts the sound and customary practices in the area of disclosure of test results, but it also conflicts with the rights given to individuals under W. V. Stat. § 16-3C-3(a)(2), wherein disclosure of test results is permitted to any person who secures a specific release of test results executed by the subject of the test. Consequently, the notice and consent form itself should permit the designation of reinsurers and others who reasonably ought to have access to test results. In addition, a limited sort of disclosure must be permitted to the Medical Information Bureau, since this sort of disclosure greatly decreases the opportunity for fraud in this area (and I can tell you, speaking for this company, fraud has been quite a problem in this area). We do note, however, that many statutes

and regulations dealing with disclosures by insurers to the Medical Information Bureau or other information exchanges prohibit the reporting of a positive HIV test result code as such, instead requiring that the report be made under a generic, nonspecific blood test code which is used for many sorts of abnormal test results. At Northwestern, we only report positive HIV test results under this generic blood test code, and it is our understanding that all other insurers do likewise.

Section 5.7. HIV testing for insurance purposes is routinely done in two areas: first, testing is done of all individuals who are buying a certain product or who meet certain age and amount requirements, and, second, testing is done for individuals in particular cases where the insured's health history suggests the possibility for HIV infection. We recommend that the first sentence of this section be appropriately clarified. In the second sentence, we think there is an incorrect bit of wording just before the colon: we think the phrase should read "denied coverage on the basis of AIDS-related testing . . . ." As to the actual test sequence set out in this section, we note that the customary description of ELISA testing often refers to two-out-of-three positive ELISA tests. Furthermore, many of the statutes and regulations in this area wisely permit some flexibility for the continuing improvement in testing protocols by also permitting other test protocols which may be shown to be of equal or greater reliability as the ELISA/ELISA/Western blot protocol.

Section 5.8. We think the last bit of phrasing in this section is objectionable. The sentence should not broadly prohibit the denial of coverage based on "AIDS-related concerns," but rather should state that coverage cannot be denied based on "AIDS-related testing."

The Notice and Consent Form. The notice and consent form reflects in various respects the draft regulation as it now exists, so we will not repeat the various points made above. We presume it will be appropriately modified to reflect the final regulation. However, let me note a few specific points of objection to the form. First, we think it is inappropriate and not at all helpful at all to applicants to have a precise listing in the form of the various persons to whom disclosure can be made. On the same score, we think it would be simply overloading the applicant, and would in fact be detrimental to the applicant's understanding of what is going on, to provide him with copies of specific statutes. Ironically, the more information you provide, the greater the likelihood that none of it will be read.

Second, we would suggest that the instruction to "initial please" on the second page be replaced by something more generic, such as "mark the appropriate space." Experience suggests that if you instruct people to initial something, no small number of people will put in a check or an "x" or some other indication, leaving it quite unclear as to what the insurer is to do.

Finally, we think the blank in which an expiration date is to be placed on the third page offers the same opportunity for error and confusion. It would be much better if the sentence simply stated that the consent expires in a certain number of days (for example, 30 or 60) after the date the form is signed.

We would be very happy to answer any questions you have about these comments. Please feel free to call collect at 414-299-7347.

Very truly yours,

Harvey W. Pogoriler

cc: J. Bruce Ferguson, ACLI

3194LINSL/HWP:kl

ThePrudential

H. Roger Pancoast
Vice President and Counsel

The Prudential Insurance Company of America
South-Central Home Office
One Prudential Plaza
P.O. Box 4579, Jacksonville, FL 32231-0038
904 391-3273

Proposed AIDS Regulation
(Chapter 33, Series 27)

June 28, 1990

B. Kenneth Huffman, Esq.
General Counsel
State of West Virginia
Office of Insurance Commissioner
2019 Washington Street, E.
Charleston, West Virginia 25305

Dear Mr. Huffman:

On behalf of The Prudential Insurance Company of America, I would like to present the following comments on your proposed regulation series 27 concerning AIDS.

- Prudential supports the Department's position in prohibiting inquiries to determine an applicant's sexual preference or lifestyle.
- We would suggest some amendments to Section 5.1 prohibiting testing in connection with group insurance.
- We believe Section 5.6 prohibiting disclosure to MIB or to reinsurers would not be in the public interest.
- We are concerned that the notice and consent form could be interpreted to prohibit use of non-invasive screening procedures such as urine testing.

To deal with the last point first, Prudential prefers, wherever possible, to use a non-invasive screening process such as urine testing, rather than drawing a blood sample which requires actually puncturing the skin. However, we use this only as a screening procedure and, if the test comes back positive, we then use the blood testing procedures which are specified in the proposed regulation and consent form.

Urine HIV testing is a very accurate method for pre-screening insurance applicants to eliminate the need for drawing blood of those whose Urine HIV test is negative. For every 100,000 Urine HIV tests conducted about 99,750 will be negative. On the other 250 cases a blood sample would be

requested for additional testing. Of those that submit a follow-up blood sample, our experience shows that 90% will have positive results. No one is denied coverage based on HIV test results unless the ELISA-ELISA-Western Blot protocol has been used on a serum sample.

This means that the overwhelming majority of people who do not test positive on this screening test would never have to have a blood test and this is certainly a great benefit to them. However, we are concerned that the wording of the consent form might be taken to mean that the urine test screening is not permitted.

We are concerned with Section 5.1 prohibiting AIDS underwriting in group life or accident and sickness insurance. Normally, of course, we do not underwrite large group insurance, but there are situations, such as small groups and late entrants, where underwriting is a standard and necessary procedure both with Prudential and in the industry.

The availability and affordability of health insurance, particularly for small groups, has become a serious national problem. We feel that the ultimate effect of this portion of the regulation would be to increase the cost and decrease the availability to smaller employer groups in the state of West Virginia. Prudential believes that underwriting of small group products is essential for solvency; this portion of the proposed regulation would call into question our ability to offer coverage to small employer groups in West Virginia.

It is also important that underwriting for late entrants continue to be allowed. This is the classic situation where insurers have to fear adverse selection and, again, considerations of cost and solvency would suggest that underwriting is necessary in these situations.

I would further comment, for the record, that I am not familiar with any other restrictions on underwriting group insurance in the state of West Virginia and question whether it is a valid public purpose to make these restrictions in the case of AIDS only. I further suggest that this goes beyond the statutory authorization for these regulations which is contained in Section J of West Virginia Code Section 16-3C-3 which authorizes the Commissioner to "develop standards regarding consent for use by insurers which test for the presence of the HIV antibody."

We have similar concerns with Section 5.6 which prohibits disclosure of the fact or results of the test to MIB or to reinsurers. We believe that adequate safeguards are built into the MIB procedures and NAIC Guidelines to protect both the privacy needs of the applicants and the legitimate business interests of the insurers.

Prudential, because of its size, does not reinsure much of its life or health business, but we are a reinsurer ourselves. We believe that this prohibition would impair our ability to reinsure risks offered to us by West Virginia companies and would, in fact, discriminate against both West Virginia insureds and companies operating in your state.

Lastly, as indicated earlier, Prudential is sensitive to the privacy concerns of our applicants, and we do not make or permit any inquiries into sexual preference. In this and other respects, we support the NAIC guidelines on AIDS underwriting and fully support the basic thrust of this regulation in requiring informed consent for testing and restriction of disclosure to necessary business purposes.

I thank you for the opportunity to have input into this proposed regulation. If a public hearing is called, I would appreciate being notified and the opportunity to present these comments at the hearing.

Sincerely,

H R Pancrast

HRP/mb

Vice President and Counsel

New England Mutual
Life Insurance Company
501 Boylston Street
Boston, Massachusetts 02117
617 578 2405

The New England
Your Financial Partner

Cindy D. Yanofsky
Attorney

June 29, 1990

B. Kenneth Huffman, Esq. General Counsel
Office of the Insurance Commissioner
2019 Washington Street, East
Charleston, WV 25305

RE: Proposed Regulation Series 27 concerning AIDS

Dear Mr. Huffman:

I am writing on behalf of New England Mutual Life Insurance Company with comments to the above described proposed regulation.

1. In Section 5.1, the regulation prohibits testing for group life and accident and sickness insurance. It is not clear from the prohibition whether the prohibition applies to all accident and health or just group. The regulation should be clarified.

   As for group underwriting, typically late entrants, supplemental insurance applicants and small groups are treated individually; that is, typical group underwriting methods are not applied. A further clarification of the provision would allow testing in the group area where individual underwriting is the norm.

   By offering the above clarification, the Company should not be considered to have accepted that the law gives the Commissioner the authority to prohibit testing for group insurance.

2. In Section 5.3, the applicant must demonstrate an actual understanding. The regulation, however, does not describe by what standard the applicant's actual understanding is to be determined. Either the requirement of actual understanding should be deleted or if the applicant signs the consent form, the regulation should provide that by signing, the applicant is evidencing actual understanding.

3. The regulation refers in various sections to the applicant. The applicant and the proposed insured are not always the same and where different, it is the insured that will be tested. The word "applicant" should be replaced with "proposed insured" where appropriate.

4. In Section 5.6, contractors of the insurer are not allowed to receive the test results. Insurers do not always do their own underwriting. Sometimes, outside contractors are hired to do the underwriting and in such a case, the contractor must receive the test result. The regulation should be amended to allow disclosure to contractors of the insurer who have the responsibility to make underwriting decisions on behalf of the insurer.

   Concerning the prohibition on disclosure to MIB, MIB has gone to great lengths to code all illnesses and to protect the confidentiality of positive HIV tests by using an abnormal blood code instead of a specific code for positive HIV tests. To prevent fraud on the part of proposed insureds, it is imperative that disclosure be made to MIB. The Company respectfully requests that the prohibition on disclosure to MIB be removed.

   Please note that the West Virginia code section referred to in the regulation specifically allows release of test results to "any person who secures a specific release of test results executed by the subject of the test." This law would allow disclosure to MIB, contractors and reinsurers upon written authorization by the proposed insured. The proposed regulation, therefore, conflicts with the West Virginia law cited.

5. In Section 5.7, the last sentence appears to have a typographical error as it switches from testing to "AIDS related questions". If a person states on the application that he/she has been diagnosed by a person in the medical profession as having AIDS, the insurer does not subject the person to an HIV test. The word "question" should be replaced with "testing".

6. In Section 6.2, a statement is made that the consent form shall be as set out in the Appendix.

   To ensure that consent forms are being properly delivered and executed, the fewer state mandated forms required, the better. The Company requests that the form set forth in the Appendix be a guide and that Company forms using similar language that cover all of the subjects set forth in the form in the Appendix be allowed. If need be, companies could file on an information basis their particular form with the Department so that the Department is aware of the variations used by particular companies.

7. The reference in the consent form to release of test result information by health care professionals would appear to confuse a proposed insured. The portions of Sections 16-3C-3 and 16-3C-4 attached to the form do not describe when a health care provider is required to disclose information to the Centers for Disease Control (CDC) or identified sex partners.

   As I understand, the CDC is only notified upon a diagnosis of AIDS. Since insurance testing does not result in a diagnosis of AIDS, the CDC would not be notified on the basis of a positive HIV test. The reference then to the CDC should be deleted.

   In addition, the insurer does not ask for names of sex partners or contacts or persons who have shared needles so no disclosure to these persons could ever be made on the basis of the insurer requested HIV test. A physician or health department person would have had to

have consulted with the individual outside of the insurance testing arena, therefore including this potential disclosure would mislead the proposed insured. Since the insurer testing process would not result in such a disclosure, the reference to such disclosures should be deleted from the consent form. Instead, at the time the health department or physician is discussing contacts, they should inform the individual that disclosure of the subject's HIV status may be made known to the contacts.

Finally, Section 16-3C-3(J) of the West Virginia Code states that "nothing in this section is applicable to any insurer regulated under Chapter Thirty-Three of this Code: Provided that the Commissioner of Insurance shall develop standards regarding consent for use by insurers which test for the presence of the HIV antibody". As a result of this code section, it is requested that the references in the consent form to Section 16-3C-3 and 4 and the attaching of the full sections to the form be removed.

Thank you for your attention to these comments. If you have any questions or would like suggestions for sample informed consent form language, I would be happy to assist you.

Sincerely,

Cindy D. Yanofsky

CDY:eg

cc: J. Bruce Ferguson
Legislative Director
American Council of Life Insurance
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599

PROVIDENT
COMPANIES

1 FOUNTAIN SQUARE
CHATTANOOGA, TN 37402

June 29, 1990

Mr. B. Kenneth Huffman, General Counsel
Office of the Insurance Commissioner
State of West Virginia
2019 Washington Street, East
Charleston, West Virginia 25305

Re: Proposed West Virginia Legislative Rule Chapter 33, Series 27 - AIDS

Dear Mr. Huffman:

I appreciate this opportunity of being able to give you the comments of Provident Life and Accident Insurance Company on the above-captioned proposal. While most of the provisions of this proposal are certainly acceptable to our Company and may be necessary to protect prospective insureds, there are some provisions in this proposal with which we have serious concerns. These provisions are the ones that prohibit any type of AIDS-related testing for group life and health insurance, and the provisions which prohibit sharing any test results or even the fact that a test has been conducted with the Medical Information Bureau (MIB) or reinsurers.

It is essential in group life and health insurance that AIDS be treated like any other life threatening illness, and that HIV infection be treated with the seriousness that it deserves. There are some types of groups that would not be written if insurance companies could not underwrite the risk. These include such groups as associations where the risk of adverse selection is great. Certainly, insurance companies should be able to request HIV tests, as well as tests for any other type of condition which might render an individual uninsurable. To do otherwise is unfair discrimination. If insurance companies are not allowed to request AIDS-related testing and information with respect to underwritten group policies, they probably will not write the group at all, or the premium will be greatly increased. This is certainly not fair to persons who would not test positive, and is a form of reverse discrimination. We question that this benefits West Virginia consumers.

Furthermore, with respect to group insurance, it is essential that companies be able to request evidence of insurability for late applicants. If insurers were not able to do this, adverse selection in group insurance would be tremendous. Why should AIDS or HIV infection be treated any differently from any other life threatening condition with regard to late applicants? Certainly, that individual had a right to enroll when first eligible and did not choose to do so. He should have to furnish evidence of insurability whether he would test positive to HIV infection, whether he has a heart condition, whether he has some form of malignancy, etc. To prohibit testing for HIV infection and not prohibit testing for heart conditions, malignancies, drug addition, etc. is unfair discrimination against those persons who could not furnish evidence of

insurability and would be rejected while the person who would test positive to the AIDS virus is just as uninsurable, but would be accepted simply because the insurance company could not request a blood test.

Certainly, with respect to group insurance, both in requiring evidence of insurability as a condition of coverage and requiring evidence of insurability for late applicants, persons who test positive to the AIDS virus should be treated just like anyone else, and testing should be permitted.

We also object to the provision in the proposal that prohibits insurance companies from reporting test results or even the fact that a test has been conducted to MIB or reinsurers. Certainly, with regard to reinsurers, that company should have the test results just as the initial insurance company does, since they are on the risk. While we agree that reinsurers should have to have some system to assure confidentiality of AIDS tests results, we believe it is essential, in order to obtain reinsurance, that the insurance company have the right to share test results with their reinsurance companies.

Furthermore, we believe that insurance companies should be able to report a positive HIV test result under the generic blood code to MIB just as we are able to do in other states. If insurers were not permitted to do this, they would have to require testing of everyone, no matter what the amount, and this would have an impact on the cost of insurance. Is this really beneficial to West Virginia consumers? There are a number of things that can be reported under a generic blood code to MIB, and it does not mean that the report indicates the individual has AIDS or a positive test result to the AIDS virus. It only indicates to member insurers who obtain the report that there is some problem, and they should seek further information to make certain that individual meets their insurability standards. If insurance companies are prohibited from making any type of report to MIB, I believe it is certain that most insurance companies will then require HIV testing for all applicants for individual life and health insurance. Since this is a costly procedure, and the insurance company has to pay the cost, the insurance premiums will be increased for all West Virginia residents.

For all of these reasons, we urge you to amend the proposed rule to permit HIV testing for group insurance for both individually underwritten group coverages and late applicants, and to permit the report of test results to reinsurers, as well as test results to MIB under a generic blood code. If you have any questions concerning our comments, please do not hesitate to call me.

Sincerely yours,

Mary Ann Blanks/bb

Mary Ann Blanks
Assistant General Counsel

MAB:rb/0629r09

cc: Terri Sorota
Health Insurance Association of America
1025 Connecticut Avenue, NW
Suite 1200
Washington, DC 20036

Mr. J. Bruce Ferguson
Legislative Director
American Council of Life Insurance
1001 Pennsylvania Avenue, NW
Washington, DC 20004-2599

STATE OF WEST VIRGINIA

GASTON CAPERTON
GOVERNOR

OFFICES OF THE
INSURANCE COMMISSIONER
2019 WASHINGTON STREET, EAST
CHARLESTON, WEST VIRGINIA 25305

ADMINISTRATIVE DIVISION
304) 348-3354

FACSIMILE
(304) 348-0412

HANLEY C. CLARK
INSURANCE COMMISSIONER

June 28, 1990

Terri Sorota, Senior Counsel
Legal/State Affairs
Health Insurance Association
of America
1025 Connecticut Avenue
Washington, DC 20036-3998

Dear Ms Sorota:

This is pursuant to your request of June 27, 1990, that a public hearing be held on Series 27, Chapter 33, AIDS Regulations. Due to the lateness of your request, and a tight time table in order for regulations submitted this year to be considered by the legislature, this Agency must exercise its option, as stipulated in the West Virginia Code §29A-3A-6, to limit public comment on the proposed AIDS Regulations to the submission of written materials. The official deadline for the submission of such materials is July 2, 1990. Consequently, we must respectfully deny your request for a public hearing.

If you or representatives of HIAA wish to discuss your concerns regarding the AIDS Regulations, please contact our General Counsel, Keith Huffman. However, these discussions would not be part of the official record toward the promulgation of such regulations. To the extent that you wish to preserve your comments in the rulemaking history of these regulations, they should be reduced to writing and submitted accordingly.

Sincerely,

Donna Hanna-Walker

Donna Hanna-Walker
Assistant to the Commissioner

DHW/iw

HIAA

Health Insurance Association of America

June 27, 1990

Honorable Hanley C. Clark
Insurance Commissioner
Department of Insurance
2019 Washington Street East
Charleston, WV 25305

Dear Commissioner Clark:

I am writing this letter on behalf of the Health Insurance Association of America (HIAA), to request that you hold a public hearing on the adoption of proposed Chapter 33 Series 27 AIDS regulations.

HIAA is a trade association of 320 private health insurance companies which provide health insurance for 95 million Americans, including a substantial number of West Virginians.

We have serious concerns about the proposed AIDS regulations and the impact they may have on the availability and affordability of health insurance coverage in West Virginia.

While we intend to submit written comments outlining our concerns, we believe that regulations of this magnitude should not be adopted without the opportunity for public debate. HIAA, therefore, urges you to hold a public hearing before adopting final regulations.

Sincerely,

Terri Sorota

Terri Sorota
Senior Counsel
Legal/State Affairs

TLS/kt

1025 Connecticut Avenue, NW Washington, DC 20036-3998 202/223-7780 Telecopier 202/223-7897

STATE OF WEST VIRGINIA

GASTON CAPERTON
GOVERNOR

OFFICES OF THE
INSURANCE COMMISSIONER
2019 WASHINGTON STREET, EAST
CHARLESTON, WEST VIRGINIA 25305

HANLEY C. CLARK
INSURANCE COMMISSIONER

LEGAL DIVISION
304) 348-0401

FACSIMILE
(304) 348-0412

June 27, 1990

T. Randolph Cox, Esq.
Spilman, Thomas, Battle & Klostermeyer
Suite 1200, United Center
Post Office Box 273
Charleston, WV 25321

Re: June 26, 1990, Request for Public Hearing on Series 27, Chapter 33, AIDS Regulations

Dear Randy:

This is in response to your June 26 request as referenced above. Due to the lateness of your request, and a tight time table in order for regulations submitted this year to be considered by the legislature, this agency must exercise its option, pursuant to West Virginia Code §29A-3A-6, to limit public comment on the proposed AIDS Regulations to the submission of written materials. As you are aware, the official deadline for the submission of such materials is July 2, 1990. We must, therefore, respectfully deny your request for a public hearing.

If you or representatives of your client wish to discuss your concerns with regard to the AIDS Regulations with me, please let me know. However, these discussions would not be part of the official record toward the promulgation of such regulations. To the extent that you wish to preserve your comments in the rulemaking history of these regulations, they should be reduced to writing and submitted accordingly.

Thank you very much for your attention to this matter.

Sincerely,

B. Keith Huffman
General Counsel

BKH/iw

COPY
HC
DW
LKH

LAW OFFICES
SPILMAN, THOMAS, BATTLE & KLOSTERMEYER

Suite 1200 United Center
P. O. Box 273
Charleston, West Virginia 25321-0273
Telephone (304) 340-3800
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☐ Reply to Above Address

Suite 205 CB&T Executive Plaza
990 Elmer Prince Dr.
Morgantown, West Virginia 26505
Telephone (304) 599-8175
Telecopier (304) 599-8229
☐ Reply to Above Address

June 26, 1990

By Hand Delivery

RECEIVED
JUN 27 1990
W VA. INS. DEPT.

Hanley Clark, Commissioner
West Virginia Insurance Department
2019 Washington Street, E.
Charleston, West Virginia 25305

Re: Series 27, Chapter 33, Aids Regulations

Dear Commissioner Clark:

I am submitting this request on behalf of the American Council of Life Insurance ("ACLI"), a trade association comprised of 616 companies which have 93.6% of the life insurance in force in legal reserve life insurance companies. Three hundred and ninety-seven of the ACLI's member companies are licensed to do business in West Virginia, and account for 95.4% of the life insurance in force in the State.

On behalf of ACLI, I hereby request the opportunity for a public hearing with respect to Series 27, Chapter 33, Aids Regulations which are currently proposed by the West Virginia Insurance Commissioner in order to present oral testimony and comments with respect to said proposed regulations. The proposed regulations have very serious implications for the life and health insurance industry in West Virginia and ACLI believes the opportunity for a public hearing is necessary in order to adequately express its concerns with respect to said regulations. Thank you for your consideration in this matter.

Sincerely yours,

T. Randolph Cox
Counsel for the
American Council of Life Insurance

TRC:krh

Mutual of Omaha Plaza
Omaha, Nebraska 68175
Phone: (402) 342-7600

Keith
Jerry
Donna
HCC

LAW DIVISION FACSIMILE TRANSMITTAL

FAX #: (402) 978-5906

Date: 7/2/90 Time: 4:50 p.m.

* *

FROM: James McCabe
DEPARTMENT: Law Division
DIRECT #(402) 978-2633

TO: Hanley C. Clark
COMPANY: Insurance Commission
CITY, STATE: Charleston WV.
FAX #: 304-348-0412

FAX SENT BY: Sue Miner
PHONE #: (402) 342-7600 X3920

THERE ARE 3 PAGES INCLUDING THIS COVER SHEET IN THIS TRANSMITTAL.

PROBLEMS: Please Call Sender

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Is verification of receipt requested: Yes X No _____

(If yes, (check one): By telephone Y By return fax _____

* *

REMARKS/SPECIAL INSTRUCTIONS:

Revised 12/89

Mutual of Omaha Companies

James E. McCabe
Senior Counsel
(402) 978-2633
Telecopy (402) 978-5906

July 2, 1990

Hanley C. Clark
Commissioner of Insurance
2019 Washington St., E.
Charleston, WV 25305

RE: Proposed West Virginia AIDS Regulations

Dear Commissioner Clark:

The proposed West Virginia AIDS Regulation has been reviewed and the following comments are respectfully submitted:

1. Section 5.1 which prohibits AIDS related testing for group life or accident and sickness insurance is objectionable, as anti-selection can be present in group insurance as well as individual insurance.

2. Section 5.3 is ambiguous and needs clarification. The language "The applicant should demonstrate an actual understanding that the test is being performed . . ." establishes a vague standard with no accompanying directives or instructions on what constitutes compliance on the part of the insurer.

3. Section 5.6 should be modified to allow insurers to report test results to the MIB and to reinsurers. Reporting to the MIB would be done pursuant to a generic code as authorized in other state regulations.

4. Section 5.7 needs clarification. Insurers need the right to test for cause so long as the testing is not discriminatory and not based on sex, sexual orientation, age, etc. In addition, the first paragraph of this Section states that "Testing is required to be administered on a non-discriminatory basis for all individuals in the same class . . .". The term "class" is not defined.

5. While we don't disagree with the intent of Section 5.9, this section appears to contradict Section 5.5 which requires that test results be released to the individual unless otherwise designated by the individual.

6. The Notice and Consent form contains a space for the insertion of the date on which the authorization will expire. This sentence should be eliminated from the form. Many problems could arise if such a sentence remains as part of the form. For example, what if no date is inserted? How is the expiration date ascertained?

Respectfully submitted,

James E. McCabe
Senior Counsel

JEM07021.90/sam

KH
Jerry
Donna
HC

CORPORATE LAW DEPARTMENT
STATE FARM INSURANCE COMPANIES
One State Farm Plaza, E-6
Bloomington, Illinois 61710

Telecopy Cover Sheet

Send to: B. Keith Huffman

Telecopy Machine No: 304-348-0412

****

From: William H. Shepherd

4 Total pages (including this cover sheet).

*Sender: Evelyn Chandler. Phone (309) 766-4914

Date: July 2, 1990

REMARKS: Proposed Rule Regulation

****

ANY TELECOPY TRANSMISSIONS MAY BE SENT TO CORPORATE LAW VIA OUR NEC/Nefax Bit-III MACHINE, TELEPHONE NO. (309) 766-4909 OR OUR CANON FAX-450 MACHINE, TELEPHONE NO. (309) 766-1637.

****

☑ If checked, please confirm receipt of document with *Sender.

State Farm Insurance Companies

One State Farm Plaza
Bloomington, Il 61710

William G. Shepherd
Assistant Counsel
Telephone (309) 766-4914

July 2, 1990

Mr. B. Keith Huffman
General Counsel
Office of the Insurance Commissioner
2019 Washington Street, East
Charleston, West Virginia 25305

RE: Proposed AIDS Regulation
(Ch. 33, Series 27)

Dear Mr. Huffman:

This statement is submitted on behalf of the State Farm Insurance Companies ("State Farm"). State Farm Life provides life insurance and State Farm Mutual provides health insurance in West Virginia. The proposed AIDS regulation would severely impact the ability of State Farm to provide efficiently priced insurance products in the life and health area. The proposed regulation appears to pre-date the more recent analysis of the AIDS testing issue. State Farm respectfully suggests that the West Virginia Department of Insurance not adopt the proposed rule and consider the comments and current day business practices of the insurance industry affected by this rule.

First, State Farm supports the general intent of the proposed regulation to the extent that it provides a rational, predictable regulatory scheme that assists the insurer, the consumer, and the regulator to fulfill the intent of the West Virginia state legislature. State Farm believes that there are several areas in the proposed administrative regulation that necessitate comment and suggestions for change. They are as follows:

1. Group Insurance - AIDS Testing Prohibition

The proposed rule in subsection 5.1 prohibits "AIDS-related testing in connection with the application for group life or accident and sickness insurance..." (emphasis added). The prohibition of AIDS testing for group life or group accident or sickness insurance doesn't reflect group insurance underwriting practices. The group insurer must be allowed the opportunity to test for HIV infection. The general prohibition should be changed to allow testing for group insurance policies where the number of individuals insured might be relatively small or where there could be "late entrants" where individual underwriting is required. The underwriting risk and subsequent liability for an insured with

the HIV infection is as important in a group policy as it is in an individual policy. The general prohibition upon HIV testing in group policies should be deleted in its entirety so as to provide the insurer the needed flexibility to underwrite in accordance with the risk.

2. HIV Testing Protocol

The proposed regulation at Section 5.7(c) sets forth a three-step protocol for HIV testing. The third step is the Western Blot blood test which is to "confirm" the two previous ELISA tests. The use of the word "confirms" is not as precise as other language that should be used. The factual situation is that the testing protocol could result in "indeterminate" results; the testing could possibly be done at a time when the person tested is converting to positive status. Insurers must be allowed to decline insurance to someone possessing this risk characteristic. We suggest that the rule be clarified to allow an adverse underwriting decision to be based on an indeterminate Western Blot result.

A related problem is found in Section 5.8; the current standard protocol is that if two out of three ELISA tests are positive, then the Western Blot test is used. The proposed protocol of ELISA and Western Blot where one negative stops the testing is not in line with current protocol.

3. Applicant "Actual Understanding"

The proposed regulation of Section 5.3 requires that the "applicant should demonstrate an actual understanding that the test is being performed..." The insurer should not be required to interpret an applicant's subjective understanding of the test procedure. The directive of the proposed rule is too vague and impossible to enforce. An objective demonstration such as signing the appropriate disclosure form should suffice.

4. Disclosure of HIV Tests Results

Subsection 5.6 of the proposed regulation prohibits the disclosure of the AIDS test results to virtually everyone. Certainly, there are insurance support entities that should know or need to know the test results in the appropriate circumstances. The disclosure prohibition should be clarified and certain identifiable insurance entities should be excepted from the prohibition. First, the Medical Information Bureau should be allowed to receive the generic blood test code as required by its current rule. MIB acts as a clearinghouse or "fraud alert" which serves the useful function of moderating insurance rates. The disclosure should also be allowable when made to reinsurers, insurance affiliates and contractors. For purposes of protecting confidentiality, the disclosure to the MIB and the three entities mentioned above would not detract from that goal. There are numerous instances when the insurer must disclose the result in order to run the business of life or health insurance. Reinsurers must be able to determine that a potential reinsurance risk has received negative HIV

test result. An affiliated insurer has a need to know a HIV test result where applications are made simultaneously to several affiliated insurers; this would prevent the need for multiple testing. The contractor must know the result of a test when the contractor provides services or participates in the underwriting or claims process. The insurance industry is well-acquainted with the need of confidentiality and non-disclosure of sensitive information. It should be allowed the latitude to disclosure test results for appropriate business purposes.

5. Consent Form

The consent form attached as appendix A has certain problems that can be easily resolved. First, the form requires that the statutory Sections 16-3C-3 and 16-3C-4 be attached to the form for the use of the person being tested. This requirement imposes the duty upon an insurer to provide material to an applicant that is commonly available from governmental sources. This requirement goes beyond rules concerning consent to HIV testing and unduly complicates an insurer's business practices. This obligation is made more difficult by the tendency of legislatures to amend statutes making it difficult for insurers to keep the required forms current.

Also, the consent form specifies that blood is to be withdrawn "by needle;" the lancet or "finger prick" method should not be prohibited since it is a medically recognized method of blood withdrawal. We suggest that "by needle" be deleted.

In conclusion, State Farm appreciates the opportunity to comment on this proposed regulation and respectfully requests that revisions of it be made as suggested above.

Sincerely,

William G. Shepherd
Assistant Counsel

WGS/ejc

P.S.: Please note that this letter is being telefaxed on July 2, 1990; the original is being delivered by overnight mail.