WEST VIRGINIA CODE: §33-15A-6

§33-15A-6. Disclosure and performance standards for long-term care insurance.

(a) The commissioner may adopt rules that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

(b) No long-term care insurance policy may:

(1) Be canceled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(c) Preexisting condition:

(1) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in subdivision (1), subsection (e), section four of this article shall use a definition of "preexisting condition" that is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within six months preceding the effective date of coverage of an insured person.

(2) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in subdivision (1), subsection (e), section four of this article may exclude coverage for a loss or confinement that is the result of a preexisting condition unless loss or confinement begins within six months following the effective date of coverage of an insured person.

(3) The commissioner may extend the limitation periods set forth in subdivision (1) and (2), subsection (c) of this section as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of "preexisting condition" does not prohibit an insurer from using an

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application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subdivision (2), subsection (c) of this section expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subdivision (2), subsection (c) of this section.

(d) Prior hospitalization/institutionalization:

(1) No long-term care insurance policy may be delivered or issued for delivery in this state if the policy:

(A) Conditions eligibility for any benefits on a prior hospitalization requirement;

(B) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(C) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

(2)(A) A long-term care insurance policy containing post-confinement, post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

(B) A long-term care insurance policy or rider that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty days.

(3) No long-term care insurance policy or rider that provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty days after discharge from the institution.

(e) The commissioner may adopt rules establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the rule.

(f) Right to return - free look:

(1) Long-term care insurance applicants shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-

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term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in subdivision (1), subsection (e), section four of this article, the applicant is not satisfied for any reason.

(2) This subsection shall also apply to denials of applications and any refund must be made within thirty days of the return or denial.

(g) Outline of coverage:

(1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

(A) The commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(B) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.

(C) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(D) In the case of a policy issued to a group defined in subdivision (1), subsection (e), section four of this article, an outline of coverage shall not be required to be delivered, provided that the information described in paragraphs (A) through (F), inclusive, subdivision (2) of this subsection is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the commissioner.

(2) The outline of coverage shall include:

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

(B) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(C) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(D) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contain governing contractual provisions;

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(E) A description of the terms under which the policy or certificate may be returned and premium refunded;

(F) A brief description of the relationship of cost of care and benefits; and

(G) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended.

(h) A certificate issued pursuant to a group long-term care insurance policy that is delivered or issued for delivery in this state shall include:

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

(2) A statement of the principal exclusions, reductions and limitations contained in the policy; and

(3) A statement that the group master policy determines governing contractual provisions.

(i) If an applicant for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty days after the date of approval.

(j) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

(1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

(3) Any exclusions, reductions and limitations on benefits of long-term care;

(4) A statement that any long-term care inflation protection option required by section eight of the commissioner's rule relating to long-term care insurance is not available under this policy; and

(5) If applicable to the policy type, the summary shall also include:

(A) A disclosure of the effects of exercising other rights under the policy;

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(B) A disclosure of guarantees related to long-term care costs of insurance charges; and

(C) Current and projected maximum lifetime benefits.

(k) Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

(1) Any long-term care benefits paid out during the month;

(2) An explanation of any changes in the policy, for example death benefits or cash values, due to long-term care benefits being paid out; and

(3) The amount of long-term care benefits existing or remaining.

(l) If a claim under a long-term care insurance contract is denied, the issuer shall, within sixty days of the date of a written request by the policyholder or certificate holder, or a representative thereof:

(1) Provide a written explanation of the reasons for the denial; and

(2) Make available all information directly related to the denial.

(m) Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this article.

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