WEST VIRGINIA LEGISLATURE

REGULAR SESSION, 1989

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ENROLLED

HOUSE BILL No. 2526

(By Mr. Speaker, Mr. Chambers and Mrs. Burke)

[Signature]

By Request of the Executive

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Passed ___________________________ April 4, 1989

In Effect Ninety Days from Passage
AN ACT to amend and reenact section two, article twenty-three, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended; and to amend and reenact section four, article twenty-four of said chapter; to further amend said chapter by adding thereto a new article, designated article fifteen-a; and to amend and reenact section twenty-four, article twenty-five-a of said chapter, all relating to the West Virginia long-term care insurance act; short title; declaration of policy and purpose; applicability; definitions; extraterritorial jurisdiction; group long-term care insurance; disclosure and performance standards for long-term care insurance; and severability.

Be it enacted by the Legislature of West Virginia:

That section two, article twenty-three, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted; that section four, article twenty-four of said chapter be amended and reenacted; that said chapter be further amended by adding thereto a new article, designated article fifteen-a; and that section twenty-four, article twenty-five-a of said chapter be amended and reenacted, all to read as follows:

ARTICLE 15A. WEST VIRGINIA LONG-TERM CARE INSURANCE ACT.

This article may be known and cited as the West Virginia Long-Term Care Insurance Act.


The purpose of this act is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.


The requirements of this act shall apply to policies delivered or issued for delivery in this state on or after the effective date of this act. This act is not intended to supersede the obligations of entities subject to this act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this act, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance.


(a) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide benefits for not less than twenty-four consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual policies or riders whether issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization. Any insurance policy which is offered primarily to provide basic medicare supplement insurance.
coverage, basic hospital expense coverage, basic medi-
cal-surgical expense coverage, hospital confinement
indemnity coverage, major medical expense coverage,
disability income protection coverage, accident only
coverage, specified disease or specified accident cover-
age, or limited benefit health coverage which also
contains long-term care insurance benefits for at least
six months shall comply with the provisions of this act.

(b) "Applicant" means:

(1) In the case of an individual long-term care
insurance policy, the person who seeks to contract for
benefits, and

(2) In the case of a group long-term care insurance
policy, the proposed certificate holder.

(c) "Certificate" means, for the purposes of this act,
any certificate issued under a group long-term care
insurance policy, which policy has been delivered or
issued for delivery in this state.

(d) "Commissioner" means the insurance commis-
ioner of this state.

(e) "Group long-term care insurance" means a long-
term care insurance policy which is delivered or issued
for delivery in this state and issued to:

(1) One or more employers or labor organizations, or
to a trust or to the trustees of a fund established by one
or more employers or labor organizations, or a combi-
nation thereof, for employees or former employees or a
combination thereof or for members or former members
or a combination thereof, of the labor organizations; or

(2) Any professional, trade or occupational association
for its members or former or retired members, or
combination thereof, if such association:

(a) Is composed of individuals all of whom are or were
actively engaged in the same profession, trade or
occupation; and

(b) Has been maintained in good faith for purposes
other than obtaining insurance; or
(3) An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for the purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and by-laws which provide that:

(a) The association or associations hold regular meetings not less than annually to further purposes of the members;

(b) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(c) The members have voting privileges and representation on the governing board and committees.

Thirty days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(4) A group other than as described in subsections (e)(1), (e)(2) and (e)(3), subject to a finding by the commissioner that:

(a) The issuance of the group policy is not contrary to the best interest of the public;

(b) The issuance of the group policy would result in economies of acquisition or administration;

(c) The benefits are reasonable in relation to the premiums charged.

(f) “Policy” means, for the purposes of this act, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health,
hospital, or medical service corporation; prepaid health
plan; health maintenance organization or any similar
organization.

§33-15A-5. Extraterritorial jurisdiction—group long-
term care insurance.

(a) No group long-term care insurance coverage may
be offered to a resident of this state under a group policy
issued in another state to a group described in section
4(e)(4) unless this state or another state having statutory
and regulatory long-term care insurance requirements
substantially similar to those adopted in this state has
made a determination that such requirements have been
met.

(b) Any such group policy form and any group
policy form issued under the group, shall be filed
with the commissioner for informational purposes with
evidence of the determination required by subsection (a)
of this section.

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

(a) The commissioner may adopt rules and regula-
tions that include standards for full and fair disclosure
setting forth the manner, content and required disclo-
sures 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, termina-
tion of insurance, continuation or conversion, probation-
ary 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; or

(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 section 4(e)(1) shall use a definition
of “preexisting condition” which is more restrictive than
the following: Preexisting condition means a condition
for which medical advice or treatment was recom-
mended 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 section 4(e)(1) may exclude
coverage for a loss or confinement which is the result
of a preexisting condition unless such loss or confine-
ment 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 sections 6(c)(1) and (2) above 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 application form
designed to elicit a 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 section 6(c)(2) 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 section 6(c)(2).

(d) Prior hospitalization/institutionalization:

(1) Effective July 1, 1990, no long-term care insurance policy may be delivered or issued for delivery in this state if such policy:

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

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.

(2) Effective July 1, 1990, a long-term care insurance policy containing any limitations or conditions for eligibility other than those prohibited above in paragraph (1) 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.

(a) A long-term care insurance policy containing a benefit advertised, marketed or offered as a home health care or home care benefit may not condition receipt of benefits on a prior institutionalization requirement.

(b) A long-term care insurance policy which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days for which benefits are paid.

(3) No long-term care insurance policy which 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 regulations estab-
lishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

(f) Right to return-free look:

(1) Individual long-term care insurance policyholders shall have the right to return the policy within ten days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within ten days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

(2) A person insured under a long-term care insurance policy issued pursuant to a direct response solicitation shall have the right to return the policy within thirty days of its delivery and to have the premium refunded if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within thirty days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

(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 which 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.

(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.

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

(f) A brief description of the relationship of cost of care and benefits.

(h) A certificate issued pursuant to a group long-term care insurance policy which policy 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) Any policy advertising, marketing or offering long-term care or nursing home insurance benefits shall

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

ARTICLE 23. FRATERNAL BENEFIT SOCIETIES.

§33-23-2. Other provisions of chapter applicable.

Every fraternal benefit society shall be governed and be subject, to the same extent as other insurers transacting like kinds of insurance, to the following articles of this chapter:

- Article one [33-1-1 et seq.] (definitions),
- Article two [33-2-1 et seq.] (insurance commissioner),
- Article four [33-4-1 et seq.] (general provisions),
- Article ten [33-10-1 et seq.] (rehabilitation and liquidation),
- Article eleven [33-11-1 et seq.] (unfair trade practices),
- Article thirteen [33-13-1 et seq.] (life insurance), and

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS AND HEALTH SERVICE CORPORATIONS.

§33-24-4. Exemptions; applicability of other laws.

Every such corporation is hereby declared to be a scientific, nonprofit institution and as such exempt from the payment of all property and other taxes. Every such corporation, to the same extent such provisions are applicable to insurers transacting similar kinds of insurance and not inconsistent with the provisions of this article, shall be governed by and be subject to the provisions, as hereinbelow indicated, of the following articles of this chapter: Article two [33-2-1 et seq.] (insurance commissioner) except that under section nine [33-2-9] of article two examinations shall be conducted at least once every four years, article four [33-4-1 et seq.] (general provisions) except that section sixteen [33-4-16]...
of article four shall not be applicable thereto, article ten [33-10-1 et seq.] (rehabilitation and liquidation), article eleven [33-11-1 et seq.] (unfair practices and frauds), article twelve [33-12-1 et seq.] (agents, brokers and solicitors) except that the agent’s license fee shall be five dollars, article fifteen-a [33-15A-1 et seq.] (long-term care insurance), section three-c [33-16-3c], article sixteen (group accident and sickness insurance), section three-d [33-16-3d], article sixteen (medicare supplement) and article twenty-eight [33-28-1 et seq.] (individual accident and sickness insurance minimum standards); and no other provision of this chapter shall apply to such corporations unless specifically made applicable by the provisions of this article. If, however, any such corporation shall be converted into a corporation organized for a pecuniary profit, or if it shall transact business without having obtained a license as required by section five [33-24-5] of this article, it shall thereupon forfeit its right to these exemptions.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.


(1) Except as otherwise provided in this article, provisions of the insurance law and provisions of hospital or medical service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this article. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this state except with respect to its health maintenance corporation activities authorized and regulated pursuant to this article.

(2) Factually accurate advertising or solicitation regarding the range of services provided, the premiums and copayments charged, the sites of services and hours of operation, and any other quantifiable, nonprofessional aspects of its operation by a health maintenance organization granted a certificate of authority, or its
representative shall not be construed to violate any provision of law relating to solicitation or advertising by health professions: *Provided,* That nothing contained herein shall be construed as authorizing any solicitation or advertising which identifies or refers to any individual provider, or makes any qualitative judgment concerning any provider.

(3) Any health maintenance organization authorized under this article shall not be deemed to be practicing medicine and shall be exempt from the provision of chapter thirty of this code, relating to the practice of medicine.

(4) Any long-term care insurance policy delivered or issued for delivery in this state by a health maintenance organization shall comply with the provisions of article fifteen-a of this chapter.
The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Frederick L. Fisher  
Chairman Senate Committee

Bernard V. Kelley  
Chairman House Committee

Originating in the House.

Takes effect ninety days from passage.

J. C. Wells  
Clerk of the Senate

Donald T. Kepp  
Clerk of the House of Delegates

Jim A. Toler  
President of the Senate

Robert C. Chlum  
Speaker of the House of Delegates

The within is presented this the 25th day of April, 1989.

Gaston Caperton  
Governor