WEST VIRGINIA LEGISLATURE

2023 REGULAR SESSION

Introduced

House Bill 2201

By Delegate Hornbuckle

[Introduced January 11, 2023; Referred to the

Committee on Banking and Insurance then Health

and Human Resources]

A BILL to amend and reenact §33-13-25 of the Code of West Virginia, 1931, as amended, to amend and reenact §33-14-8 of said code; to amend and reenact §33-15A-6 of said code; to amend and reenact §33-15-1b of said code; to amend said code by adding thereto new section, designated §33-16-11a; and to amend and reenact §33-25-8 of said code, all relating to prohibiting an insurer from declining or limiting coverage on a person under any life insurance policy, major medical coverage policy, disability insurance policy, or long-term care insurance policy solely due to the status of that person as a living organ donor.

Be it enacted by the Legislature of West Virginia:

ARTICLE 13. LIFE INSURANCE.

§33-13-25. Limitation of liability.

(a) No policy of life insurance ~~shall~~ may be delivered or issued for delivery in this state if it contains a provision which excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except that a policy may contain provisions excluding or restricting coverage as specified therein ~~in the event of~~ if there is a death under any one or more of the following circumstances:

(1) Death as a result, directly or indirectly, of war, declared or undeclared, or of action by military forces, or of any act or hazard of such war or action, or of service in the military, naval, or air forces or in civilian forces auxiliary thereto, or from any cause while a member of ~~such~~ the military, naval, or air forces of any country at war, declared or undeclared, or of any country engaged in such military action;

(2) Death as a result of aviation;

(3) Death as a result of a specified hazardous occupation or occupations;

(4) Death while the insured is outside continental United States and Canada;

(5) Death within two years from the date of issue of the policy as a result of suicide, while sane or insane.

(b) A policy which contains any exclusion or restriction pursuant to subsection (a) of this

section shall also provide that ~~in the event of~~ if there is a death under the circumstances to which any such exclusion or restriction is applicable, the insurer ~~will~~ shall pay an amount not less than a reserve determined according to the commissioners' reserve valuation method upon the basis of the mortality table and interest rate specified in the policy for the calculation of nonforfeiture benefits (or if the policy provides for no such benefits, computed according to a mortality table and interest rate determined by the insurer and specified in the policy) with adjustment for indebtedness or dividend credit.

(c) This section ~~shall~~ may not apply to group life insurance, accident and sickness insurance, reinsurance, or annuities, or to any provision in a life insurance policy relating to disability benefits or to additional benefits ~~in the event of~~ if there is a death by accident or accidental means.

(d) Notwithstanding any other provision of law, it is unlawful to:

(1) Decline or limit coverage on a person under any life insurance policy, solely due to the status of that person as a living organ donor. The Insurance Commissioner may take such actions authorized under this section that are necessary to enforce this section;

(2) Preclude an insured from donating all or part of an organ as a condition of continuing to receive a life insurance policy; or

(3) Otherwise discriminate in the offering, issuance, cancellation, amount of the coverage, price, or any other condition of a life insurance policy, for a person, based solely and without any additional actuarial risks upon the status of the person as a living organ donor.

~~(d)~~ (e) Nothing contained in this section ~~shall~~ may prohibit any provision which in the opinion of the commissioner is more favorable to the policyholder than a provision permitted by this section.

ARTICLE 14. GROUP LIFE INSURANCE.

§33-14-8. Group life standard provisions.

(a) Except as set forth in subsection (b), below, no policy of group life insurance ~~shall~~ may

be delivered in this state unless it contains in substance the standard provisions as required by §33-14-9 to 18, inclusive, of this code, or provisions which in the opinion of the commissioner are more favorable to the persons insured, or at least as favorable to the persons insured and more favorable to the policyholder.

(b) ~~The provisions of~~ §33-14-14 to §33-14-18, inclusive, of this code ~~shall~~ may not apply to policies issued to a creditor to insure debtors of such creditor. The standard provisions required for individual life insurance policies ~~shall~~ may not apply to group life insurance policies. If the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the commissioner is or are equitable to the insured persons and to the policyholder, but nothing herein ~~shall~~ may be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies.

(c) Notwithstanding any other provision of this article, it is unlawful to:

(1) Decline or limit coverage on a person under any policy of group life insurance policy solely due to the status of that person as a living organ donor. The Insurance Commissioner may take such actions authorized under this section that are necessary to enforce this section;

(2) Preclude an insured from donating all or part of an organ as a condition of continuing to receive; or

(3) Otherwise discriminate in the offering, issuance, cancellation, amount of the coverage, price, or any other condition of a group life insurance policy for a person, based solely and without any additional actuarial risks upon the status of the person as a living organ donor.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-1b. Rates, individual major medical policies.

(a) No individual major medical coverage policy may be approved by the commissioner for use in this state unless:

(1) The premium rates for the policy, after adjustment for any difference in policy benefits,

which include, but are not limited to, deductibles, copayments and levels of care management, do not exceed by more than 30 percent the premium rates charged by the same insurer on any and all other individual major medical policies for those individuals with similar characteristics and factors, which the insurer has had approved by the commissioner within a five-year period preceding the date of the new policy filing by the insurer;

(2) The insurer files with the commissioner the opinion of a qualified actuary or other person acceptable to the commissioner which states:

(A) That the policy premium rate is in compliance with subdivision (1) of this subsection; and

(B) That the anticipated loss ratio for the combined experience of the policy taken together with all other individual major medical coverage policies which the insurer has had approved by the commissioner within a five-year period preceding the date of the new policy filing is equal to or greater than the loss ratio requirements set forth in §33-15-1a of this code.

(3) For a period of three years after the effective date of this section, an insurer may have one or more policy forms which exceed the 130 percent requirement of subdivision (2) of this subsection: *Provided,* That any rate schedule increase for ~~such~~ the policy form ~~shall~~ may not exceed 33 and one-third percent of the rate schedule increase for the lowest rate policy form. During the final 12 months of this three- year period, an insurer may request an extension of time for compliance from the commissioner based on extenuating circumstances.

(b) An initial individual major medical policy form may be disapproved by the commissioner if the commissioner determines that the rates proposed by the insurer for the policy form are set at a level substantially less than rates charged by other insurers for comparable insurance coverage.

(c) Nothing contained in this section may be construed to prevent the use of age, sex, area, industry, occupational, and avocational factors in setting premium rates or to prevent the use of different rates after approval by the commissioner for smokers and nonsmokers or for any other habit or habits of an insured person which have a statistically proven effect on the health of the

person. Nothing contained in this section ~~shall~~ may preclude the establishment of a substandard classification based upon the health condition of the insured: *Provided,* That the initial classification may not be changed adversely to the insured after the initial issuance of the policy.

(d) The commissioner ~~has the right~~ may, upon application by an insurer, and for good cause shown, to grant relief from any requirement of this section.

(e) Notwithstanding any other provision of this article, it is unlawful to:

(1) Decline or limit coverage on a person under major medical coverage policy solely due to the status of that person as a living organ donor. The Insurance Commissioner may take such actions authorized under this section that are necessary to enforce this section;

(2) Preclude an insured from donating all or part of an organ as a condition of continuing to receive a major medical coverage policy; or

(3) Otherwise discriminate in the offering, issuance, cancellation, amount of the coverage, price, or any other condition of a major medical coverage policy for a person, based solely and without any additional actuarial risks upon the status of the person as a living organ donor.

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

§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 §33-15-4(e)(1) of this code ~~shall~~ may 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 §33-15-4(e)(1) of this code 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 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~~ the 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~~ may not require a prior institutional stay of more than 30 days.

(3) No long-term care insurance policy or rider that provides benefits only following institutionalization shall condition ~~such~~ the benefits upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge from the institution.

(e) Notwithstanding any other provision of this article, it is unlawful to:

(1) Decline or limit coverage on a person under long-term care insurance policy, solely due to the status of that person as a living organ donor. The Insurance Commissioner may take such actions authorized under this section that are necessary to enforce this section;

(2) Preclude an insured from donating all or part of an organ as a condition of continuing to receive a long-term care insurance policy; or

(3) Otherwise discriminate in the offering, issuance, cancellation, amount of the coverage, price, or any other condition of a life insurance policy, disability insurance policy, or long-term care insurance policy for a person, based solely and without any additional actuarial risks upon the status of the person as a living organ donor.

~~(e)~~ (f) 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)~~ (g) Right to return - free look:

(1) Long-term care insurance applicants ~~shall have the right to~~ may return the policy or certificate within 30 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-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~~ may return the policy or certificate within 30 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 §33-15-4(e)(1) of this code, the applicant is not satisfied for any reason.

(2) This subsection shall also apply to denials of applications and any refund ~~must~~ shall be made within 30 days of the return or denial.

~~(g)~~ (h) 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~~ shall 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~~ shall be presented in conjunction with any application or enrollment form.

(D) ~~In the case of~~ If a policy is issued to a group defined in §33-15-4(e)(1) of this code, an outline of coverage ~~shall~~ may 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;

(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)~~ (i) 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)~~ (j) 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 30 days after the date of approval.

~~(j)~~ (k) 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;

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

(C) Current and projected maximum lifetime benefits.

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

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-11a. Group policies not to decline or limit coverage solely due to status of person as a living organ donor.

Notwithstanding any other provision of law, it is unlawful to:

(1) Decline or limit coverage on a person under a group major medical coverage policy solely due to the status of that person as a living organ donor. The Insurance Commissioner may take such actions authorized under this section that are necessary to enforce this section;

(2) Preclude an insured from donating all or part of an organ as a condition of continuing to receive a group major medical coverage policy; or

(3) Otherwise discriminate in the offering, issuance, cancellation, amount of the coverage, price, or any other condition of a group major medical coverage policy for a person, based solely and without any additional actuarial risks upon the status of the person as a living organ donor.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8. Commissioner to enforce article; approval of contracts, forms, and rates; reserve fund; membership fee.

(a) ~~It shall be the duty of the~~ The commissioner ~~to~~ shall enforce the provisions of this article.

(b) No ~~such~~ corporation ~~shall~~ may deliver or issue for delivery any subscriber's contract, changes in the terms of ~~such~~ the contract, application, rider, or endorsement until a copy thereof and the rates pertaining thereto have been filed with and approved by the commissioner. All such forms filed with the commissioner ~~shall be deemed~~ are considered approved after the expiration of 30 days from the date of ~~such~~ the filing unless the commissioner ~~shall have~~ has disapproved the same, stating his or her reasons for ~~such~~ the disapproval in writing, except that ~~such~~ the period may be extended for an additional period not to exceed 15 days upon written notice thereof from the commissioner to the applicant. ~~Such~~ The forms may be used prior to the expiration of ~~such~~ those periods if written approval thereof has been received from the commissioner.

(c) No rates to be charged subscribers ~~shall~~ may be used or established by any such corporation unless and until the ~~same~~ rates have been filed with the commissioner and approved by him or her. The procedure for ~~such~~ the filing and approval shall be the same as that prescribed in subsection (b) of this section for the approval of forms. The commissioner shall approve all ~~such~~ rates which are not excessive, inadequate, or unfairly discriminatory.

(d) The commissioner shall pass upon the actuarial soundness of all direct health care services plans.

(e) The corporation shall accumulate a fund to be derived from a minimum of two percent of every subscriber's monthly premium which shall be known as a contingency and liability reserve fund except that the same shall not exceed an amount equal to three months' average obligation of said corporation, nor ~~shall~~ may it fall below a minimum of one month's average obligation of said corporation. Said fund shall be expended by the corporation according to rules and regulations to be promulgated by the commissioner.

In addition to the above requirements, every subscriber shall pay into the corporation a membership fee equal to one monthly premium. The membership fee shall be collected in full by

~~said~~ the corporation within 90 days of said subscriber's application for membership.

(f) Each such rate filing, and each such form filing made with the commissioner pursuant to this section is subject to the filing fee of §33-6-34 of this code.

(g) Notwithstanding any other provision of this article, it is unlawful to:

(1) Decline or limit coverage on a person under any health corporation major medical coverage policy solely due to the status of that person as a living organ donor. The Insurance Commissioner may take such actions authorized under this section that are necessary to enforce this section;

(2) Preclude an insured from donating all or part of an organ as a condition of continuing to receive a major medical coverage policy; or

(3) Otherwise discriminate in the offering, issuance, cancellation, amount of the coverage, price, or any other condition of a major medical coverage policy for a person, based solely and without any additional actuarial risks upon the status of the person as a living organ donor.

NOTE: The purpose of this bill is to prohibit an insurer from declining or limiting coverage on a person under any life insurance policy, major medical coverage policy, disability insurance policy, or long-term care insurance policy solely due to the status of that person as a living organ donor.

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