

**TITLE 114  
EMERGENCY RULE  
INSURANCE COMMISSIONER**

**SERIES 88  
WV AFFORDABLE HEALTH CARE PLAN**

Section

- 114-88-1. General.
- 114-88-2. Submission and Evaluation of Proposals.
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**§114-88-1. General.**

1.1. Scope. -- The purpose of this rule is to implement W. Va. Code §33-16F-1 *et seq.* relating to the program created in 2009 by the Legislature (Enr. Com. Sub. for S.B. 552) to encourage the development of affordable alternatives to the health insurance plans currently available in the private market.

1.2. Authority. -- W. Va. Code §§33-2-10 and 33-16F-10.

1.3. Filing Date. -- September 16, 2009.

1.4. Effective Date. -- October 19, 2009.

**§114-88-2. Submission and Evaluation of Proposals.**

2.1. Any insurer licensed in West Virginia to sell accident and sickness insurance may submit a proposal at any time to participate in the “Affordable Health Insurance Plan” program by submitting an application to the West Virginia Offices of the Insurance Commissioner (“OIC”) in the format set forth on the OIC website.

2.2. An application submitted pursuant to this rule must include at least two proposed plans, one of which must include catastrophic coverage and each of which must include prescription drug benefits.

2.3. Any plan approved under this program shall not be considered to be providing major medical or similar comprehensive type coverage.

2.4. Each proposal must include a childhood immunization benefit that includes coverage for the cost of vaccines and their administration for the prevention of polio, measles, mumps, rubella, diphtheria, pertussis, tetanus, hepatitis-b, and haemophilus influenzae-b. This benefit must be included in all policies that cover the children of the insured, shall be available to such children under the age of seventeen, and shall be covered without any deductible, per-visit charge and/or copayment, for the cost of the vaccine, if incurred by the health care provider, and all costs of the administration of vaccines.

2.5. With respect to any policy in which reimbursement or indemnity for laboratory or X-ray services are covered, reimbursement or indemnity may not be denied for any of the

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following services, and such policy may apply to such benefits the same deductibles, coinsurance and other limitations as apply to other covered services under the policy:

a. Mammogram -- When performed at the direction of a licensed physician who deems the test medically appropriate and consistent with the current guidelines from the United States Preventive Services Task Force.

b. For women age eighteen and over, a Pap smear (either conventional or liquid-based cytology, whichever is medically appropriate) and a test for the human papilloma virus (HPV) (when medically appropriate), each to be consistent with the current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists.

c. A colorectal cancer examination and laboratory testing for any nonsymptomatic person fifty years of age or older, or a symptomatic person under fifty years of age, that is performed for colorectal cancer screening or diagnostic purposes at the direction of a licensed physician. The tests are an annual fecal occult blood test, a flexible sigmoidoscopy repeated every five years, a colonoscopy repeated every ten years and a double contrast barium enema repeated every five years. A symptomatic person is (i) An individual who experiences a change in bowel habits, rectal bleeding or stomach cramps that are persistent; or (ii) an individual who poses a higher than average risk for colorectal cancer because he or she has had colorectal cancer or polyps, inflammatory bowel disease, or an immediate family history of such conditions.

2.6. Filing fees. Notwithstanding the provisions of W. Va. Code §33-6-34, plan entities are exempt from the payment of fees for filing rates and forms.

2.7. Commissioner's decisions on proposals. Notwithstanding the provisions of W. Va. Code §33-2-13, the Commissioner is not required to grant a hearing or to issue an order in response to a written demand from a plan entity aggrieved by a decision by the Commissioner to refuse to approve a proposed plan.

**§114-88-3. Eligibility.**

3.1. Proposals may be submitted for employer group plans or any other group that the Commissioner determines would benefit from such a plan.

3.2. Enrollment in any plan approved under this rule is limited to groups that have not been covered under any other group plan in the last six months and to individuals who have not been covered and have not been eligible for coverage under a health insurance plan (other than COBRA coverage) unless coverage in the last six months was lost due to loss of a job, death of

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or divorce from a covered spouse or termination from a public program due to inability to meet income or categorical requirements.