

TITLE 114  
LEGISLATIVE RULE  
INSURANCE COMMISSIONER

SERIES 54  
GROUP ACCIDENT AND SICKNESS INSURANCE  
ISSUANCE, PORTABILITY AND MARKETING REQUIREMENTS

§114-54-1. General.

1.1. Scope and applicability. -- This rule applies to health benefit plans issued in connection with a group health plan by insurance companies; fraternal benefit societies; hospital, medical, dental and health service corporations and health care corporations; and health maintenance organizations, and delivered or issued for delivery in this state on and after the effective date hereof for group health plan years beginning after June 30, 1997, or as otherwise provided in this rule. This rule does not apply to:

a. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group insurance;

b. Individual policies or contracts issued to eligible individuals, as defined in W. Va. Code §33-15-2a(e);

c. A health benefit plan for any group health plan year if, on the first day of the group health plan year, the group health plan has fewer than two participants who are current employees;

d. Coverage under the West Virginia Public Employees Insurance Act (W. Va. Code §5 16 1 et seq.): Provided, That this rule applies to a health benefit plan issued by a health insurer to provide medical care under the West Virginia Public Employees Insurance Act;

e. Coverage under Medicare or Medicaid: Provided, That this rule applies to a health benefit plan issued by a health insurer to provide medical care under Medicare or Medicaid;

f. Coverage that consists solely of excepted benefits;

g. Coverage under health benefit plans issued to or through bona fide associations, if such coverage is not related to a group health plan;

h. Accident and sickness insurance contracts covering members of fraternal benefit societies organized pursuant to West Virginia Code §§33-23-1 et seq., if not issued in connection with a group health plan;

i. Credit accident and sickness insurance subject to WV 114CSR6 "Regulation of Credit Life Insurance and Credit Accident and Sickness Insurance;"

j. Medicare supplement insurance policies subject to WV 114CSR24 "Medicare Supplement Insurance;"

k. Long term care insurance policies subject to WV 114CSR32 "Long Term Care Insurance;"

l. Individual limited benefits policies subject to the requirements of W. Va. Code §33 16E 1 et seq.

The requirements contained in this rule are in addition to WV 114CSR39 "Group Accident and Sickness Insurance Minimum Policy Coverage Standards" and any other applicable rules previously adopted.

1.2. A health insurer may provide greater rights to policyholders, persons covered under a health benefit plan and their dependents than the minimum standards set forth in this rule.

1.3. Authority. -- W. Va. Code §§33 2 10, 33 16 3(f) and 33-16D-6.

1.4. Filing Date. -- April 30, 1999.

1.5. Effective Date. -- April 30, 1999.

1.6. Purpose. -- The purpose of this legislative rule is to provide for implementation of state standards meeting federal requirements under the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and to facilitate public understanding of these standards.

§114-54-2. Definitions.

As used in this legislative rule:

2.1. "Affiliation period" means, with respect to a health maintenance organization, a period that begins on an individual's enrollment date, runs concurrently with any waiting period under the group health plan, expires before coverage is effective and during which the health maintenance organization need not provide medical care and may not charge any premium to the individual.

2.2. "Bona fide association" means an association which:

a. has been organized in good faith for purposes other than that of obtaining or providing insurance;

- b. has a minimum of one hundred members;
- c. has been actively in existence for at least five years;
- d. has a constitution and bylaws providing that:
  - 1. the association holds annual meetings to further purposes of its members;
  - 2. except in the case of credit unions, the association collects dues or solicits contributions from members; and
  - 3. the members have voting privileges and representation on the governing board and committees that exist under the authority of the association;
- e. does not condition membership in the association on any health status-related factor relating to an individual;
- f. makes accident and sickness insurance offered through the association available to all members regardless of any health status-related factor relating to members or individuals eligible for coverage through a member;
- g. does not make accident and sickness insurance coverage offered through the association available other than in connection with a member of the association; and
- h. meets any additional requirements as may be set forth in chapter thirty-three of the West Virginia Code or by rule.

2.3. "Commissioner" means the commissioner of insurance.

2.4. "Creditable coverage" means, with respect to an individual, coverage of the individual after June 30, 1996, under any of the following, other than coverage consisting solely of excepted benefits:

- a. A group health plan;
- b. A health benefit plan;
- c. Medicare Part A or Part B, 42 U.S.C. §1395 et seq.; Medicaid, 42 U.S.C. §1396a et seq. (other than coverage consisting solely of benefits under section 1928 of the Social Security Act); Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), 10 U.S.C., Chapter 55; and a medical care program of the Indian Health Service or of a tribal organization;
- d. A public health plan or a health benefits risk pool sponsored by any state of the United States or by the District of Columbia, as defined in regulations promulgated by the federal Secretary of Health and Human Services; a health plan offered under 5 U.S.C.,

chapter 89; or a health benefit plan as defined in the Peace Corps Act, 22 U.S.C. §2504(e).

2.5. “Days of creditable coverage” means the aggregate of the periods of creditable coverage, as defined in section 2701(a)(3) of the Public Health Service Act.

2.6. “Dependent” means an eligible employee's spouse or any unmarried child or stepchild under the age of eighteen or unmarried, dependent child or stepchild under age (23) twenty three if a full time student at an accredited school.

2.7. “Eligible employee” means an employee, including an individual who either works or resides in this state, who meets all requirements for enrollment in a health benefit plan.

2.8. “Employer” means a large employer or a small employer. In connection with a partnership to which this rule applies, employer includes the partnership in relation to any partner, and in connection with a health benefit plan issued through one or more bona fide associations, “employer” includes a bona fide association acting as policyholder for the employers.

2.9. “Enrollment date” means an individual’s first day of coverage under a group health plan or, if there is a waiting period, the first day of the waiting period.

2.10. “Excepted benefits” means:

a. Any policy of liability insurance or contract supplemental thereto; coverage only for accident or disability income insurance or any combination thereof; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; workers' compensation insurance; or other similar insurance under which benefits for medical care are secondary or incidental to other insurance benefits;

b. If offered separately or otherwise not as an integral part of a health benefit plan or the group health plan in connection with which it is issued, a policy providing benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof, dental or vision benefits, or other similar, limited benefits;

c. If offered as independent, noncoordinated benefits under separate policies or certificates, specified disease or illness coverage, hospital indemnity or other fixed indemnity insurance, or coverage, such as Medicare supplement insurance, supplemental to a group health plan; or

d. A policy of accident and sickness insurance covering a period of less than one year.

2.11. “Group health plan” means an employee welfare benefit plan, including a church plan or a governmental plan, all as defined in section three of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1002, to the extent that the plan provides medical care. For purposes of this rule, “group health plan” includes any plan, fund or

program which would not (but for this subsection) be a group health plan and which is established or maintained by a partnership, to the extent that such plan, fund or program provides medical care to present or former partners or their dependents (as defined under terms of the plan, fund or program).

2.12. "Health benefit plan" means benefits consisting of medical care provided directly, through insurance or reimbursement, or indirectly, including items and services paid for as medical care, under any hospital or medical expense incurred policy or certificate; hospital, medical or health service corporation contract; health maintenance organization contract; or plan provided by a multiple employer trust or a multiple employer welfare arrangement. "Health benefit plan" does not include excepted benefits.

2.13. "Health insurer" means an entity licensed by the commissioner to transact accident and sickness insurance in this state and subject to chapter thirty-three of the West Virginia Code. "Health insurer" does not include a group health plan.

2.14. "Health status-related factor" means an individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) or disability.

2.15. "Large employer" means any person, firm, corporation, partnership or bona fide association actively engaged in business in the state of West Virginia who employed an average of at least fifty-one (51) eligible employees on business days during the preceding calendar year and employs at least two employees on the first day of its group health plan year.

2.16. "Late enrollee" means an individual, other than one who enrolls during a special enrollment period, who enrolls under a health benefit plan or a group health plan in connection with which it is issued other than during the first period in which the individual is eligible to enroll under terms of the health benefit plan or group health plan.

2.17. "Medical care" means amounts paid for, or paid for insurance covering, the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, including amounts paid for transportation primarily for and essential to such care.

2.18. "Medical care provider" means an individual licensed or similarly authorized to provide medical care and operating within the scope of services authorized for the individual.

2.19. "Network plan" means a health benefit plan under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the health insurer. Network plans include, but are not limited to, health maintenance organizations and preferred provider arrangements.

2.20. “Policyholder” means the group health plan sponsor, as defined in section three of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1002.

2.21. “Preexisting condition exclusion” means, with respect to a health benefit plan, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the enrollment date for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before the enrollment date.

2.22. “Significant break in coverage” means a period of sixty-three consecutive days during all of which an individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

2.23. “Small employer” means any person, firm, corporation, partnership or bona fide association actively engaged in business in the state of West Virginia who, during the preceding calendar year, employed an average of no more than fifty but not fewer than two eligible employees and employs at least two employees on the first day of its group health plan year. A new employer, not in existence for all of the preceding calendar year, shall be considered a small employer if it is reasonably expected to employ an average of no more than fifty but not fewer than two eligible employees on business days in the current calendar year. Companies which are affiliated companies or which are eligible to file a combined tax return for state tax purposes shall be considered one employer.

2.24. “Special enrollment period” means a period other than the first period in which an eligible employee or a dependent is eligible to enroll under the terms of a health benefit plan or a group health plan in connection with which it is issued, without regard to other enrollment periods defined under the health benefit plan or group health plan.

2.25. “Waiting period” means, with respect to a group health plan and an eligible employee or a dependent who is potentially eligible for coverage under the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

#### §114-54-3. Limitations on Preexisting Condition Exclusion Period.

3.1. Subject to subsection 3.2 of this rule, a health insurer may impose a preexisting condition exclusion with respect to an individual covered under a health benefit plan only if medical advice, diagnosis, care or treatment for the condition was recommended or received within the six-month period which began on the six-month anniversary date preceding the individual’s enrollment date and ends on the enrollment date.

a. Medical advice, diagnosis, care or treatment is taken into account only if it is recommended by, or received from, a medical care provider.

b. Genetic information is not a preexisting condition unless a condition related to the information has been diagnosed.

c. Pregnancy may not be excluded from coverage as a preexisting condition.

3.2. Unless the child has had a significant break in coverage, no preexisting condition exclusion may be imposed with regard to a child who:

a. Is covered under any creditable coverage as of the last day of the thirty-day period beginning with the date of birth; or

b. Is adopted or placed for adoption before attaining the age of eighteen years and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This subdivision does not apply to coverage before the date of adoption or placement for adoption.

3.3. A preexisting condition exclusion may not extend for more than a twelve-month period (eighteen-month period for a late enrollee) beginning on an individual's enrollment date.

3.4. Any preexisting condition exclusion otherwise applicable to an individual shall be reduced by the number of days of creditable coverage the individual has as of the enrollment date, as provided in sections four and five of this rule.

3.5. A health maintenance organization that imposes no preexisting condition exclusions under a health benefit plan issued in connection with a particular group health plan may:

a. Impose an affiliation period if the affiliation period is applied uniformly without regard to any health status-related factors and does not exceed two months (three months for a late enrollee); or

b. File with the commissioner a proposal for an alternative method to address adverse selection, but no alternative method may be used unless approved by the commissioner.

3.6. With respect to individuals enrolled under a group health plan on the effective date of this rule for the group health plan, a health insurer may not impose a preexisting condition exclusion to the extent that:

a. An individual has met an exclusion period permitted under this section; or

b. On the effective date of this rule for the group health plan, an individual uses creditable coverage that the individual had as of his or her enrollment date in the group health plan to reduce an exclusion period permitted under this subsection.

§114-54-4. Application of Creditable Coverage to Reduce Preexisting Condition Exclusion Period.

4.1. For purposes of reducing any preexisting condition exclusion period under terms of a health benefit plan, a health insurer shall take into account all information that it obtains or that is presented on behalf of an individual to determine, based on relevant facts and circumstances, whether an individual has creditable coverage and is entitled to offset all or a portion of any preexisting condition exclusion.

4.2. For purposes of reducing any preexisting condition exclusion period under terms of a health benefit plan, a health insurer may elect to determine an individual's days of creditable coverage:

- a. By the standard method described in subsection 4.3;
- b. Subject to other applicable requirements, in any other manner that is at least as favorable to the individual as the standard method described in subsection 4.3; or
- c. By the alternative method described in subsection 4.4 with respect to any or all categories of benefits described in subsection 4.4.

4.3. A health insurer electing the standard method shall determine the days of creditable coverage by counting all the days the individual has under one or more types of creditable coverage, without regard to specific benefits included in the coverage, but:

- a. Any days in a waiting period for coverage are not days of creditable coverage; and
- b. Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

4.4. A health insurer electing the alternative method:

- a. Shall apply the alternative method uniformly to all persons covered under the health benefit plan, but creditable coverage for a category of benefits applies only for purposes of reducing a preexisting condition exclusion;
- b. Shall set forth its use of the alternative method in the health benefit plan;
- c. For each type of health benefit plan offered, shall state its use of the alternative method prominently in disclosure statements concerning the health benefit plan and to each potential policyholder at the time of offer or sale of the health benefit plan, describing in such statements the effect of using the alternative method;
- d. Shall determine the days of creditable coverage based on coverage within any or all of the following categories of benefits and not based on coverage for any other benefits:

1. Mental health benefits;
2. Substance abuse treatment;
3. Prescription drugs;
4. Dental care; and
5. Vision care;

e. Shall count creditable coverage if any level of benefits is provided within the category, but coverage under a reimbursement account or arrangement, such as a flexible spending arrangement defined in section 106(c)(2) of the Internal Revenue Code, does not constitute coverage within any category;

f. Shall:

1. First determine the amount of the individual's creditable coverage that may be counted under subsection 4.3, over a period ("determination period") of up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee);
2. Then count, for the category specified under the alternative method, all days of coverage within the category that occurred during the determination period, whether or not a significant break in coverage for that category occurs; and
3. Reduce the individual's preexisting condition exclusion period for that category by the number of days counted under paragraph 2 of subdivision f of subsection 4.4;

g. Shall use the standard method described in subsection 4.3 to determine days of creditable coverage for benefits not within any category listed in subdivision d of subsection 4.4; and

h. May, if the group health plan so chooses, apply a different preexisting condition exclusion period for benefits that are not within any category listed in subdivision d of subsection 4.4 and a different preexisting condition exclusion period with respect to each category.

4.5. An individual may demonstrate creditable coverages and waiting or affiliation periods, for a determination under either the standard or the alternative method, through:

- a. Presentation of one or more certificates of creditable coverage issued by a group health plan, health insurer or other entity that previously provided coverage for medical care; or
- b. Documents or other means if the accuracy of a certificate of creditable coverage is contested or if a certificate is unavailable when needed by an individual, such as when:

1. An entity has failed to provide a certificate within the required time period;
2. An entity is not required under federal law to provide a certificate;
3. The coverage is for a period before July 1, 1996;
4. The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate of creditable coverage to the group health plan; or
5. The individual lost a certificate of creditable coverage and is unable to obtain another certificate.

4.6. If, in the course of providing evidence (including a certificate) of creditable coverage, an individual must demonstrate dependent status, the health insurer shall treat the individual as having furnished a certificate of creditable coverage if the individual attests to such dependency and the period of such status and cooperates with the health insurer's efforts to verify the dependent status.

4.7. A health insurer may refuse to credit coverage if the individual fails to cooperate with the health insurer's efforts to verify coverage but may not consider an individual's inability to obtain a certificate of creditable coverage to be evidence of the absence of creditable coverage. A health insurer shall treat an individual as having furnished a certificate of creditable coverage if the individual attests to the period of creditable coverage, presents relevant corroborating evidence of some creditable coverage during the period, including periods before July 1, 1996, and cooperates with the health insurer's efforts to verify the individual's coverage.

a. For purposes of this subsection, cooperation includes providing, upon the health insurer's request, written authorization for the health insurer to request a certificate on behalf of the individual and cooperating in efforts to determine the validity of corroborating evidence and the dates of creditable coverage.

b. Documents that may establish creditable coverage and waiting periods or affiliation periods in the absence of a certificate include explanations of benefit claims or correspondence from a group health plan or health insurer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a health benefit plan, records from medical care providers indicating health coverage, third party statements verifying periods of coverage and any other relevant documents that evidence periods of health coverage.

c. Creditable coverages and waiting or affiliation periods may be established through means other than documentation.

4.8. A health insurer receiving information with respect to creditable coverage shall, within a reasonable time following receipt of the information:

- a. Determine the application of the individual's creditable coverage to any preexisting condition exclusion period and notify the individual of the determination; and
  - b. For any individual on whom the health insurer seeks to impose a preexisting condition exclusion period, disclose to the individual in writing:
    1. Any applicable preexisting condition exclusion period;
    2. The basis for the health insurer's determination, including the source and substance of any information on which it relied; and
    3. Any appeal procedures established by the group health plan or the health insurer, with a reasonable opportunity to submit additional evidence of creditable coverage.
- 4.9. A health insurer may modify an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, if it provides a notice of reconsideration to the individual and acts in a manner consistent with the initial determination until the final determination is made.

#### §114-54-5. Certification of Creditable Coverage.

5.1. A health insurer shall furnish information as provided in this section, without charge, for individuals covered under a health benefit plan (including a health benefit plan issued in connection with an entity or program, other than a group health plan, for which certificates are required, as provided in rules governing the entity or program) except to the extent that:

- a. Coverage was provided by another party;
- b. Another party agrees to provide information regarding coverage provided by the health insurer and actually provides a certificate of creditable coverage including all information required under subsection 5.4 of this section; or
- c. Coverage consisted of excepted benefits, but the health insurer may be required to disclose information concerning the benefits to another group health plan or health insurer that uses the alternative method of counting creditable coverage and provides coverage to an individual previously covered by the first health insurer.

5.2. For an individual whose coverage under a health benefit plan issued by the health insurer, but not the individual's participation in the group health plan, ceases, the health insurer shall provide sufficient information to the group health plan or a party designated by the group health plan to permit the group health plan or designated party to provide a certificate of creditable coverage, reflecting coverage under the health insurer's health benefit plan, upon termination of the individual's participation in the group health plan.

5.3. A health insurer shall provide a certificate of creditable coverage for periods after June 30, 1996, for each individual whose coverage under the group health plan and a health benefit plan issued by the health insurer ceases:

a. Without request by or on behalf of the covered individual, showing the last period of continuous coverage ending on the date coverage ceased:

1. For a qualified beneficiary (as defined in section 607(3) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1167(3); section 2208 of the Public Health Service Act, 42 U.S.C. §300bb-8(3); and section 4980B(g)(1) of the Internal Revenue Code, 26 U.S.C. §4980B(g)(1)) who is entitled to elect coverage under a COBRA continuation provision, as defined in W. Va. Code §33-15-2a(c), no later than the time notice is required to be furnished for a qualifying event under section 606 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1166; section 2206 of the Public Health Service Act, 42 U.S.C. §300bb-6; and section 4980B(f)(6) of the Internal Revenue Code, 26 U.S.C. §4980B(f)(6);

2. For a qualified beneficiary who has elected coverage under a COBRA continuation provision (or whose coverage has continued under the group health plan after the individual became entitled to COBRA continuation coverage) and whose coverage ceases, within a reasonable time after coverage ceases or the expiration of any grace period for nonpayment of premiums, regardless of whether the individual received a certificate under paragraph 1 of subdivision a of subsection 5.3; or

3. For a covered individual other than a qualified beneficiary entitled to elect COBRA continuation coverage, within a reasonable time after coverage ceases; and

b. Upon request by or on behalf of an individual within twenty-four months after the individual's coverage ceases, showing each period of continuous coverage ending within the twenty-four month period ending (or continuing) on the date of the request, by the earliest date that the health insurer, acting in a reasonable or prompt fashion, can provide it, even if the individual previously received a certificate under subdivision a of subsection 5.3 or this subdivision. The health insurer:

1. Shall establish a procedure for individuals to request and receive certificates under this subdivision;

2. Shall, if the individual designates another individual or entity to receive the certificate, provide the certificate to the designated party; and

3. May provide a separate certificate for each period of continuous coverage.

5.4. Every certificate of creditable coverage shall contain:

a. The date the certificate is issued;

- b. The name of the group health plan under which the health insurer provided the coverage described in the certificate;
- c. The name of the individual to whom the certificate applies and any other information necessary for the group health plan or the health insurer to identify the individual;
- d. The name, address, telephone number of the health insurer providing the certificate and the telephone number to call for further information, if different from the health insurer's telephone number;
- e. Either:
  - 1. A statement that an individual has at least eighteen months (for this purpose, 546 days is deemed to be eighteen months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage; or
  - 2. The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began; and
- f. The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate.

5.5. Except as otherwise provided in this section, an insurer must provide a certificate of creditable coverage in writing. The requirements of this subsection are satisfied if the insurer provides the required information on a form certificate prescribed by the Commissioner, or in accordance with a model certificate as provided by the Health Care Financing Authority (HCFA), unless:

- a. An individual entitled to receive a certificate requests that the certificate be sent to another group health plan or health insurer instead of to the individual;
- b. The group health plan or health insurer that would receive the certificate agrees to accept the information contained in the certificate by another means such as by telephone; and
- c. The receiving group health plan or health insurer receives the information from the sending group health plan or health insurer within the time periods required under subsection 5.3 of this section.

5.6. A certificate of creditable coverage may provide information with respect to both an eligible employee and dependents if the information is identical for each individual, or, if the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

a. A health insurer shall use reasonable efforts to determine any information needed for a certificate of creditable coverage relating to dependent coverage.

1. For a certificate required to be provided for a dependent under subdivision a of subsection 5.3, no individual certificate is required to be provided until the health insurer knows, or making reasonable efforts should know, of the dependent's cessation of coverage. If a certificate does not contain the name of any dependent of an individual covered by the certificate, the individual may demonstrate dependent status or that a child was enrolled within thirty days of birth, adoption or placement for adoption as provided in section four of this rule.

2. With respect to dependent coverage and events occurring through June 30, 1998, a health insurer:

A. May, if it cannot provide the names of dependents or related coverage information, satisfy the requirements of subdivision c, subsection 5.4 of this section, by providing the name of the eligible employee through whom a dependent is covered and specifying that the type of coverage described in the certificate is dependent coverage, such as family coverage or employee-plus-spouse coverage; and

B. Shall make reasonable efforts to obtain and provide the names of any dependent covered by the certificate where such information is requested to be provided. If a certificate does not contain the name of any dependent of an individual covered by the certificate, the individual may demonstrate that creditable coverage in the certificate covers a dependent.

5.7. If a health insurer has issued a certificate of creditable coverage for an individual who enrolls in a group health plan or health benefit plan that uses the alternative method of counting creditable coverage, the first health insurer:

a. Shall, upon request from the second group health plan or health insurer, promptly disclose to the requesting entity:

1. The categories of benefits with respect to which the requesting entity is using the alternative method of counting creditable coverage; and

2. If requested by the requesting entity, specific information that the requesting entity reasonably needs to determine the individual's creditable coverage with respect to a category; and

b. May charge the requesting entity for the reasonable cost of disclosing the information.

5.8. A health insurer shall be deemed to have satisfied the requirement for delivery of certificates of creditable coverage to individuals described in subsection 5.3 if it provides by first-class mail:

a. One certificate or separate certificates with respect to all covered individuals residing at an eligible employee's last known address, to the eligible employee and the employee's spouse at that address; and

b. A separate certificate with respect to a dependent whose last known address is different from the eligible employee's last known address, to the dependent at that individual's last known address.

5.9. If an individual described in subdivision a of subsection 5.3 designates another individual or entity to receive a certificate with respect to the individual, the health insurer may deliver a certificate to the designated party. If an individual described in subdivision b of subsection 5.3 designates another individual or entity to receive a certificate with respect to the individual, the health insurer shall deliver a certificate to the designated party.

5.10. If the accuracy of a certificate of creditable coverage is contested, or if a certificate is unavailable when needed by an individual, the individual may demonstrate creditable coverages and waiting or affiliation periods as provided in section four of this rule.

#### §114-54-6. Renewability and Modification of Coverage.

6.1. Except as provided in subsection 6.2, a health insurer shall renew or continue in force a health benefit plan at the policyholder's option. In the case of a health benefit plan offered only through one or more associations, a reference to "policyholder" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer.

6.2. A health insurer may nonrenew or discontinue a health benefit plan only at the policyholder's option or for one of the following reasons:

a. The policyholder has failed to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;

b. The policyholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage;

c. The policyholder has failed to comply with a material plan provision relating to employer contribution or group participation rules permitted under W. Va. Code chapter thirty-three;

d. The health insurer elects to discontinue offering health benefit plans:

1. Of a particular type offered to large employers or to small employers, respectively, if:

A. The health insurer gives written notice to each policyholder of that product and all covered individuals at least ninety days before the date the coverage will be discontinued;

B. On a guaranteed issue basis, the health insurer offers each large employer policyholder the option to purchase any other health benefit plan currently being offered by the health insurer to large employers, or offers each small employer policyholder the option to purchase all other health benefit plans currently being offered by the health insurer to small employers; and

C. In electing to discontinue health benefit plans of a particular type and in offering coverage under the subparagraph B of paragraph 1 of subdivision d of subsection 6.2, the health insurer acts uniformly without regard to policyholders' claims experience or any health status-related factor relating to any covered employee, member or dependent or new employees, members or dependents who may become eligible for coverage; or

2. Of all types offered to large employers or to small employers, respectively, if:

A. The health insurer gives written notice to the commissioner and to each policyholder and all covered individuals at least one hundred eighty days before the date plans are discontinued; and

B. The health insurer discontinues all, and does not renew any, health benefit plans issued to large employers or to small employers, respectively;

e. For network plans, there is no longer any enrollee under the group health plan who lives, resides or works in the health insurer's service area, and, in the case of a small employer policyholder, the health insurer applies the same criteria it would apply in denying enrollment in the health benefit plan under section seven of this rule; or

f. For a health benefit plan made available to employers only through one or more bona fide associations, the employer's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

6.3. A health insurer that elects to discontinue health benefit plans of all types offered to large employers or to small employers, respectively, in this state pursuant to paragraph 2 of subdivision d of subsection 6.2 may not issue any health benefit plan to a large employer or to a small employer, respectively, in this state for a five-year period beginning on the date of discontinuation of the last health benefit plan not renewed.

6.4. A health insurer may modify a health benefit plan's benefits only at the time of health benefit plan renewal. For health benefit plans available to small employers, other than only through one or more bona fide associations, a modification shall be effective uniformly among group health plans with that product and shall meet all other requirements under W. Va. Code chapter thirty-three.

§114-54-7. Prohibition Against Discrimination Based on a Health Status-Related Factor.

7.1. A health insurer may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the group health plan based on a health status-related factor in relation to the individual or a dependent of the individual:

a. Rules for eligibility to enroll include rules defining any applicable waiting or affiliation period and rules relating to late and special enrollment; and

b. This section does not:

1. Require a health insurer to provide particular benefits other than those provided under the terms of the group health plan or health benefit plan; or

2. Prevent a health insurer from establishing limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

7.2. A health insurer may not require an individual, as a condition of enrollment or continued enrollment, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the group health plan based on a health status-related factor in relation to the individual or a dependent of the individual.

a. Subject to the commissioner's approval pursuant to other provisions of W. Va. Code thirty-three this subsection does not:

1. Restrict the amount of premium that may be charged by a health insurer; or

2. Prevent a health insurer from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for covered individuals' adherence to a bona fide wellness program of health promotion and disease prevention.

#### §114-54-8. Special Enrollment Periods.

8.1. A health insurer shall permit individuals to enroll for coverage under terms of a health benefit plan, without regard to other enrollment dates permitted under the group health plan, if an eligible employee requests enrollment for himself or herself or, if the group health plan makes coverage available to dependents, on behalf of a dependent who is eligible but not enrolled under the group health plan, during the special enrollment period, which shall be (30) thirty days following an event described in subsections 8.2 or 8.3 with respect to the individual for whom enrollment is requested. A health insurer may impose enrollment requirements that are otherwise applicable under terms of the group health plan to individuals requesting immediate enrollment.

8.2. An individual, who previously had other coverage for medical care and for whom an eligible employee declined coverage under the group health plan, may be enrolled during

a special enrollment period if the individual has lost the other coverage for medical care and:

a. If required by the group health plan, the eligible employee stated in writing when declining the coverage, after being given a notice of the requirement for, and the consequences of failure to submit, a written statement, that coverage was declined because the individual had coverage for medical care under another group health plan or otherwise; and

b. When enrollment was declined for the individual:

1. The individual had coverage under a COBRA continuation provision, as defined in W. Va. Code §33-15-2a(c), and the coverage has been exhausted; or

2. The individual had coverage other than under a COBRA continuation provision and the coverage has been terminated due to loss of eligibility for the coverage, including loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment and any loss of eligibility after a period that is measured by reference to any of the foregoing, or termination of employer contributions towards the other coverage. For purposes of this paragraph:

A. Loss of eligibility for the coverage does not include loss of eligibility due to the eligible employee's or dependent's failure to make timely premium payments or termination of coverage for cause such as making a fraudulent claim or intentional misrepresentation of material fact in connection with the group health plan; and

B. Employer contributions include contributions by any current or former employer of the individual or another person that was contributing to coverage for the individual.

8.3. If the eligible employee has previously declined enrollment under the group health plan but acquires a dependent through marriage, birth, adoption or placement for adoption, the eligible employee or dependent may be enrolled during the special enrollment period with respect to the individual.

8.4. Enrollment of the eligible employee or dependent is effective not later than the first day of the calendar month beginning after a completed request for enrollment is received or, for a newborn or adopted child, on the date of birth, adoption or placement for adoption.

§114-54-9. Guaranteed Availability for Small Employers.

9.1. Except as provided in subsections 9.2 through 9.5, a health insurer that offers health benefit plans to small employers in this state shall:

- a. Offer to any small employer in this state all health benefit plans that are approved for sale to small employers and that the health insurer is actively marketing;
  - b. Accept any small employer that applies for any health benefit plan approved for sale to small employers and actively marketed by the health insurer; and
  - c. Under a health benefit plan issued to a small employer, accept for enrollment every individual who is eligible:
    1. To enroll under the health benefit plan in accordance with terms of the group health plan in connection with which the health benefit plan is issued;
    2. For coverage under rules of the health insurer that are uniformly applicable in this state to small employers to which the health insurer offers health benefit plans; and
    3. For coverage in accordance with W. Va. Code chapter thirty-three, and other applicable law;
  - d. With respect to an individual who meets the requirements of paragraphs 1 through 3 of subdivision c of subsection 9.1, a health insurer:
    1. Shall accept the individual for enrollment during the period in which he or she first becomes eligible to enroll under terms of the group health plan, or during a special enrollment period; and
    2. May not impose any restriction inconsistent with section seven of this rule.
- 9.2. A health insurer that offers health benefit plans to small employers through a network plan:
- a. May limit small employers that apply for the coverage to those with eligible employees (and dependents, if applicable) who live, reside or work in the network plan's service area; and
  - b. May deny coverage to small employers within the network plan's service area if the health insurer demonstrates to the commissioner that it:
    1. Will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees;
    2. Is applying subdivisions a and b of subsection 9.2 uniformly to all small employers without regard to the claims experience of those small employers, their employees and dependents or any health-status related factor relating to those employees and dependents; and

c. May not, if it denies coverage to a small employer in any service area under subdivision b of subsection 9.2, offer coverage to small employers within the service area for a period of one hundred eighty days after coverage is denied, but this subdivision does not limit a health insurer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage. Network plans offered within a service area after the one hundred eighty-day period specified in this subdivision are subject to the requirements of this section.

9.3. A health insurer may deny coverage to small employers if the health insurer:

a. Demonstrates to the commissioner that it:

1. Does not have the financial reserves necessary to underwrite additional health benefit plans of small employers in this state, or for a network plan whose service areas have been approved by the commissioner, within one or more particular service areas; and

2. Is applying paragraph 1 of subdivision a of subsection 9.3 uniformly to all small employers without regard to the claims experience of those small employers, their employees and dependents or any health-status related factor relating to those employees and dependents; and

b. May not, if it denies coverage to any small employer in this state under paragraph 1 of subdivision a of subsection 9.3, offer health benefit plans to small employers in this state for a period of one hundred eighty days after the later of:

1. The date coverage is denied; or

2. The health insurer demonstrates to the commissioner that the health insurer has sufficient financial reserves to underwrite additional coverage;

c. This subsection does not limit a health insurer's ability to renew coverage already in force or relieve the health insurer of the responsibility to renew that coverage; and

d. Health benefit plans offered to small employers after the one hundred eighty-day period specified in subdivision b of subsection 9.3 are subject to the requirements of this section.

9.4. A health insurer may establish, and apply to a small employer applying for a health benefit plan, employer contribution rules or group participation rules permitted under W. Va. Code chapter thirty-three. For purposes of this subsection, "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of eligible employees and dependents, and "group participation rule" means a requirement relating to the minimum number of eligible employees or dependents who must be enrolled in relation to a specified percentage or number of eligible individuals or employees of a small employer.

9.5. A health insurer offering a health benefit plan to small employers only through one or more bona fide associations is not required to meet the requirements of subsection 9.1.

§114-54-10. Severability.

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