

**West Virginia Offices of the Insurance Commissioner
QHP REVIEW REQUIREMENTS CHECKLIST**

GROUP MARKET

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
FORMS		
State Requirements		
<i>All references are State of West Virginia statute and regulations, unless otherwise noted</i>		
General Requirements		
		SERFF filings are submitted in accordance with SERFF procedures.
Fees	§33-6-34 §33-6-34	The fee for a Form Filing is \$50.00 per Filing. The fee for a Rate Filing is \$75 per Filing.
Submission	Informational Letter No 163 §33-3-7	All filings must be submitted through SERFF (System for Electronic Rate and Form Filing). Filing fees must be remitted via EFT (Electronic Funds Transfer) through SERFF. The company transacting insurance in this State must be licensed by the Insurance Commissioner and authorized to conduct the appropriate lines of business for the filing submitted.
Certifications		
Readability	§33-29-5 (a)(1)	The Certification of Readability must show a Test Score of 40 or better according to the Flesch Score reading ease Method or by any other comparable method.
Compliance	33-16 114-10 114-26 114-27 114-28 114-29	<u>Group Accident and Sickness</u> policy forms must comply with Chapter 16 of the WV Code. The Required provisions are found in 33-16-3. <u>Advertising</u> – Department policy to require advertising filing on all Accident & Sickness products. <u>Rate Filing Accident and Sickness</u> <u>AIDS Regulation</u> <u>Coordination of Benefits</u> <u>Temporo/Craniomandibular Disorders</u>
Applications		
		The Application, when attached to the policy, and all its attachments become part of the Entire Contract. Statements are binding only if an application is attached. Only the applicant can alter statements on the application. This Division does not permit a box on the Application, For Company Use Only , because no changes are to be made to the Entire Contract after the application has been signed by the applicant. False statements may bar recovery.
General Characteristics		
Group Acceptance		Acceptance of all members of the group, regardless of any individual's physical condition.
Master Contract		Issuance of a master contract to the administrator of the group and individual certificates of insurance (outlines of coverage) to the members.
Coordination of Benefits		Coordination of benefits with other available coverages (such as workers compensation benefits)
Benefits		Benefits are automatically determined by some preset formula which excludes individual benefit selection and thereby precludes adverse selection by not allowing poor risks to purchase higher amounts of insurance.
Legal Requirements		

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Eligible Groups	§33-16-2	Group policies must come within any of the following classifications: (1) A policy issued to an employer, who shall be considered the policyholder, insuring at least two employees of the employer, for the benefit of persons other than the employer, and conforming to the following requirements: (A) If the premium is paid by the employer the group shall comprise all employees or all of any class or classes thereof determined by conditions pertaining to the employment; or (B) If the premium is paid by the employer and the employees jointly, or by the employees, there shall be no employee participation requirement. The term "employee" as used herein is considered to include the officers, managers and employees of the employer, the partners, if the employer is a partnership, the officers, managers and employees of subsidiary or affiliated corporations of a corporate employer, and the individual proprietors, partners and employees of individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract or otherwise. The term "employer" as used herein may include any municipal or governmental corporation, unit, agency or department and the proper officers of any unincorporated municipality or department, as well as private individuals, partnerships and corporations.
Required Policy Provisions		Group policies must contain the following:
Entire Contract	§33-16-3(a)	A provision that the policy, application of the policyholder, and the individual applications submitted shall constitute the entire contract between the parties, and that all statements made by any applicant(s) shall be deemed representations and not warranties, and that no such statement shall void the insurance or reduce benefits thereunder unless contained in a written application.
Individual Certificates	§33-16-3(b)	A provision that the insurer will provide an individual certificate for each member of the group setting forth in substance the essential features of the coverage and to whom benefits are payable. If dependents are included, only one certificate need be issued for each family unit.
New Members	§33-16-3(c)	A provision that all new employees or members, in the groups or classes eligible for insurance, shall from time to time be added to such groups or classes eligible to obtain such insurance in accordance with the terms of the policy.
Prohibited Provisions	§33-16-3(d)	No provision relative to notice or proof of loss or the time for paying benefits or the time within which suit may be brought upon the policy shall be less favorable to the insured than would be permitted in the case of an individual policy by the provisions set forth in §§33-15-1 et seq.
Layoff Provision	§33-16-3(e)	A provision that all members shall be permitted to pay the premiums at the same group rate and receive the same coverages for a period not to exceed 18 months when they are involuntarily laid off from work.
Other Provisions	§33-16-3(f)	Further provisions as the commissioner shall promulgate by rule.
Mandatory Benefits		
Mental Health	45 CFR §156.115	<u>Mental Illness Coverage</u> – EHB covered under Mental health and substance use disorder services, including behavioral health treatment.
Home Health Care Coverage	§33-16-3b	Any insurer who delivers or issues for delivery in West Virginia group basic hospital expense or major medical expense coverage shall make available to the policyholder home health care coverage consistent with the provisions of this section. Home health care coverage offered shall include: 1. Services provided by a registered nurse or a licensed practical nurse. 2. Health services provided by a physical, occupational, respiratory and speech therapists. 3. Health services provided by a home health aide to the extent that such services would be covered if provided on an inpatient basis. 4. Medical supplies, drugs, medicines and laboratory services to the extent that they would be covered if provided on an inpatient basis.

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		<p>5. Services provided by a licensed midwife or a licensed nurse midwife.</p> <p>Home health care coverage may be limited to:</p> <ol style="list-style-type: none"> 1. Services provided on the written order of a licensed physician, provided such order is renewed at least every sixty days. 2. Services provided by a home health agency certified in the state in which the services are rendered or under Title XVIII [42 U.S.C. §§ 1395 et seq.] of the Social Security Act. 3. Services as set forth above without which the insured would have to be hospitalized. <p>Coverage shall be provided for at least 100 home visits per insured per policy year, with each home visit by a member of a home health care team to be considered as one visit including up to four hours of home health care services.</p> <p style="padding-left: 20px;">A. No such policy need provide such coverage to persons eligible for Medicare.</p>
Policies to Cover Nursing Services	§33-16-3e	Group policies must make available as benefits coverage for primary health care nursing services if such services are currently being reimbursed when rendered by any other duly licensed health care practitioner. No insurer may be required to pay for duplicative health care services actually provided by both a nurse and other health providers.
TMD/CMD	§33-16-3f, §114-29-4	All accident and sickness coverage which provides hospital, surgical, or major medical coverage must provide benefits for the diagnosis and treatment of temporomandibular disorders (TMD) and craniomandibular disorders (CMD). An insured shall be given the option of declining coverage for temporomandibular disorders (TMD) and craniomandibular disorders (CMD) and the insurer must provide an appropriate waiver form or incorporate such waiver form or incorporate such waiver form into the insurance policy or other evidence of coverage.
Women's Preventive Coverage	45 CFR §156.115	<u>Women's Preventive Coverage</u> – EHB covered under Preventive and wellness services and chronic disease management.
Rehabilitation Services	§33-16-3h	Insurers shall provide as benefits coverage for rehabilitation services (as defined in §33-16-3h), unless rejected by the insured.
Emergency Services	§33-16-3i	<p>Insurers shall provide as benefits coverage for emergency services. A policy, provision, contract, plan or agreement may apply to emergency services the same deductibles, coinsurance and other limitations as apply to other covered services, provided that preauthorization or precertification shall not be required.</p> <p>Every insurer shall provide coverage for emergency medical services to the extent necessary to screen and to stabilize an emergency medical condition. The insurer shall not require prior authorization of the screening services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Prior authorization of coverage shall not be required for stabilization if an emergency medical condition exists. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.</p> <p>An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation.</p> <p>Coverage of emergency services shall be subject to coinsurance, copayments and deductibles applicable under the health benefit plan.</p> <p>The emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite post-evaluation or post-stabilization services in order to avoid material deterioration of the covered person's condition.</p>
Postpartum Hospital Stay 48 Hours Normal Delivery 96 Hours C-Section	§33-16-3j	<p>If a health plan provides inpatient benefits in connection with child birth for a mother or her newborn child:</p> <p>The plan may not restrict benefits for any hospital stay following a normal vaginal delivery to less than forty-eight hours or following a cesarean section to less than ninety-six hours, or require a provider to obtain authorization for such length hospital stays.</p>
Colorectal Cancer Examination and Laboratory Testing	§33-16-3o	Reimbursement or indemnification for colorectal cancer examinations and laboratory testing may not be denied for any nonsymptomatic person 50 years of age or older, or a symptomatic person under 50 years of age, when reimbursement or indemnity for laboratory or X-ray services are covered under the policy and are performed for colorectal cancer screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery.
Reconstructive Surgery Following Mastectomy	§33-16-3p	Any policy of insurance which provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy
Clinical Trials under §33-25F-1	§33-16-3r	The provisions relating to clinical trials established in article twenty-five-f of Chapter 33 shall apply to the health benefit plans regulated by Article 16 of Chapter 33.

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Third-party reimbursement for kidney disease screening	§33-16-3s	Reimbursement or indemnification for annual kidney disease screening and laboratory testing as recommended by the National Kidney Foundation may not be denied for any person when reimbursement or indemnity for laboratory or X-ray services are covered under the policy and are performed for kidney disease screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery by the board of medicine. The tests are as follows: Any combination of blood pressure testing, urine albumin or urine protein testing and serum creatinine testing. The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered person may apply to kidney disease screening and laboratory testing.
Required coverage for dental anesthesia services	§33-16-3t	Required coverage for dental anesthesia services. (a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, 2009, provide as benefits to all subscribers and members coverage for dental anesthesia services as hereinafter set forth. (b) For purposes of this article and section, "dental anesthesia services" means general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care provided to an enrollee or insured if the enrollee or insured is: (1) Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the enrollee or insured and for whom a superior result can be expected from dental care provided under general anesthesia; or (2) A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia. (c) Prior authorization. -- An entity subject to this section may require prior authorization for general anesthesia and associated outpatient hospital or ambulatory facility charges for dental care in the same manner that prior authorization is required for these benefits in connection with other covered medical care. (d) An entity subject to this section may restrict coverage for general anesthesia and associated outpatient hospital or ambulatory facility charges unless the dental care is provided by: (1) A fully accredited specialist in pediatric dentistry; (2) A fully accredited specialist in oral and maxillofacial surgery; and (3) A dentist to whom hospital privileges have been granted. (e) Dental care coverage not required. -- The provisions of this section may not be construed to require coverage for the dental care for which the general anesthesia is provided. (f) Temporal mandibular joint disorders. -- The provisions of this section do not apply to dental care rendered for temporal mandibular joint disorders. (g) A policy, provision, contract, plan or agreement may apply to dental anesthesia services the same deductibles, coinsurance and other limitations as apply to other covered services.
AIDS Regulation	§33-16-9, §114-27	No insurer may cancel or nonrenew a policy of any insured because of diagnosis or treatment of acquired immune deficiency syndrome. See West Virginia Regulation §114-27 for more details.
Women's Preventive Coverage	45 CFR §156.115	<u>Women's Preventive Coverage</u> – EHB covered under Preventive and wellness services – and chronic disease management.
Newly Born Children	§33-6-32	All health insurance policies shall provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer within 31 days

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		after the date of birth in order to have the coverage continue beyond such 31 day period.
Newborn Screenings (Applies to policies that cover pregnancy benefits)	§16-22-3(c)	Newborn screenings shall be considered a covered benefit reimbursed to the birthing facilities by Public Employees Insurance Agency, the State Children's Health Insurance Program, the Medicaid program and all health insurers whose benefit package includes pregnancy coverage and who are licensed under chapter thirty-three of this code.
Child Immunization Services Coverage	§33-16-12	All policies shall cover the cost of child immunization services as described in W. Va. Code §16-3-5, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration. These services shall be exempt from any deductible, per-visit charge and/or copayment provisions which may be in force in these policies or contracts. This does not require that other health care services provided at the time of immunization be exempt from any deductible and/or copayment provisions.
Diabetes Coverage	§33-16-16 §33-15C-1	Except as provided in W. Va. Code §33-15-6, any policy shall include coverage for equipment and supplies listed in W. Va. Code §33-16-16(a) for treatment and/or management of diabetes for both insulin dependent and noninsulin dependent persons with diabetes and those with gestational diabetes, if medically necessary and prescribed by a licensed physician. All policies shall also include coverage for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. Coverage for this education shall be limited to visits medically necessary upon diagnosis, visits under circumstances whereby a physician diagnoses a significant change in symptoms or conditions that necessitate changes in self-management, and where a new medication or therapeutic process has been identified as medically necessary by a licensed physician. The education may be provided by the physician as part of an office visit, or by a certified diabetes educator certified by a national diabetes educator certification program, or registered dietitian registered by a nationally recognized professional association of dietitians upon the referral of a physician. Provided that such national program has been certified to the commissioner by the commissioner of the bureau of public health. Any deductible or coinsurance billed for any service shall apply on an equal basis with all other coverages provided by the insurer.
Contraceptive Coverage	45 CFR §156.115	<u>Contraceptive Coverage</u> – EHB covered under Preventive and wellness services and chronic disease management (Women's Preventive Services)
Autism Spectrum Disorders (Applies to policies delivered or renewed on or after January 1, 2012)	§33-16-3v; §147.126 Benefit maximums and service limitations have no dollar limits.	Groups with more than twenty-five eligible employees shall include coverage for diagnosis and treatment of autism spectrum disorder in individuals ages eighteen months through eighteen years. To be eligible for coverage and benefits under this section, the individual must be diagnosed with autism spectrum disorder at age 8 or younger. Such policy shall provide coverage for treatments that are medically necessary and ordered or prescribed by a licensed physician or licensed psychologist for an individual diagnosed with autism spectrum disorder, in accordance with a treatment plan developed by a certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual, subject to review by the agency every six months.
Coordination of Benefits		
COB Contract Provision	§114-28-3.1	Appendix A of §114-28 contains a model COB provision.
Flexibility	§114-28-3.2	A group contract's COB provision does not have to use the words and format of the model. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference amount plans which provide services, which pay benefits for expenses incurred, and which indemnify. No other substantive changes are allowed.
Cost Containment Provisions		
Mandatory Second Surgical Opinion		Company won't pay 100% of scheduled charges unless another physician's opinion is sought – emergencies excepted.
Pre-Admission Certification		1. Company approves the admission to the hospital (emergencies excepted).

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Concurrent Review		A review of an insured's medical care while that care is being administered. The purpose of concurrent review is to assure that the required care is being provided.
Retrospective Review		Company reviews all charges by the hospital and the physician and looks for duplicate or unreasonable fees.
Ambulatory Outpatient Services		Deductible waived and at 100%.
COBRA		
Basic Requirements		The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers with 20 employees or more on at least 50% or the working days in the previous calendar year to provide for continuation of health coverage at group rates (except group disability income benefits) for the dependents of all eligible employees with evidence of insurability.
		<ol style="list-style-type: none"> 1. Qualified beneficiaries may elect to continue coverage identical to that covered under the original health plan. 2. Employers have an obligation to determine the specific rights of the beneficiaries and inform them of same through an initial general notice known as a summary plan description. 3. Employers must notify plan administrators within 30 days of an employee's death, termination, reduced hours, and/or Medicare entitlement. 4. Multi-employer plans may be given a longer period of time than 30 days. 5. Employees, retirees and family members must notify the plan administrator within 60 days of such qualifying events as divorce or legal separation or an individual losing "dependent child" status. 6. Once notified of a "qualifying event," plan administrators must notify employees and/or family members of their rights to elect benefits identical to those received immediately before the qualifying event. 7. Qualified beneficiaries have a 60 day period to elect whether or not to continue coverage. 8. Employer Penalties – Employers who fail to comply with COBRA regulations are subject to a fine of \$100 per day per eligible insured. <p>Premiums – COBRA allows employers to charge those who elect to continue coverage 102% of the premiums the employer (company) pays for each employee. The excess 2% covers administrative duties and paperwork required of the employer. A grace period exists for the failure to pay premiums. The grace period is the longest of 30 days, the period the plan allows employees for failure to pay premiums, and the period the insurance company allows the plan or the employer for failure to pay premiums.</p>
PPACA FILINGS		Please refer to documentation in SERFF's Online Help section for instructions on completing the required PPACA fields. West Virginia does accept grandfathered and non-grandfathered related filings in one submission.
Federal Requirements <i>All references are Federal statute and regulations, unless otherwise noted</i>		
Issuer Administrative Information	N/A	Please see Administrative Data Template for details on information requested.
Licensure, Solvency, and Standing		
.	45 CFR § 156.200(b)(4)	<input type="checkbox"/> Is licensed or authorized in WV to offer health insurance; or

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Licensure and Solvency		<input type="checkbox"/> Is licenses or authorized by WV OIC to offer dental insurance. OIC Financial Conditions Division will review and confirm issuers submitting QHPs meet these standards, leveraging existing information and data sources to review the status of an issuer's license, solvency, and standing. Issuers licensed in West Virginia are not required to submit supporting documentation unless concerns are identified and additional review is required. Issuers not currently licensed are required to complete the WV licensing process; West Virginia is a NAIC Uniform Certificate of Authority Application (UCAA) participant state and accepts the UCAA Primary and Expansion Applications.
Standing		<input type="checkbox"/> Is in good standing (no outstanding sanctions imposed by the OIC).
Benefit Standards and Product Offerings		9.
Essential Health Benefits	45 CFR §156.110 §156.115 §156.120 §156.122	<input type="checkbox"/> Covers the Essential Health Benefit Package. <ul style="list-style-type: none"> <input type="checkbox"/> Ambulatory patient services <input type="checkbox"/> Emergency services <input type="checkbox"/> Hospitalization <input type="checkbox"/> Maternity and newborn care <input type="checkbox"/> Mental health and substance use disorder services, including behavioral health treatment <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Rehabilitative and habilitative services and devices <input type="checkbox"/> Laboratory services <input type="checkbox"/> Preventive and wellness services and chronic disease management <input type="checkbox"/> Pediatric services, including oral and vision care. <input type="checkbox"/> Offers coverage that is substantially equal to the benchmark plan. <input type="checkbox"/> Demonstrates actuarial equivalence of substituted benefits if substituting benefits. <input type="checkbox"/> Provides required number of drugs per category and class. <input type="checkbox"/> Provides habilitative benefits that are similar in scope, amount, and duration to benefits covered for habilitative services. In West Virginia, benchmark plan is Highmark Blue Cross Blue Shield West Virginia Super Blue Plus 2000 1000 Ded.; pediatric dental benefits are supplemented using the State's separate Children's Health Insurance Program (CHIP) program; pediatric vision benefits are supplemented using the Federal Employees Dental and Vision Insurance Program.
Cost-Sharing Requirements		

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Actuarial Value	45 CFR §156.135 §156.140 45 CFR §156.150 (for SADPs)	<input type="checkbox"/> If health insurance, offers a plan that provides one of the following actuarial values (± 2%): <input type="checkbox"/> Bronze plan (AV 60%) <input type="checkbox"/> Silver plan (AV 70%) <input type="checkbox"/> Gold plan (AV 80%) <input type="checkbox"/> Platinum plan (AV 90%) <input type="checkbox"/> Catastrophic plan FOR STAND-ALONE DENTAL ONLY <input type="checkbox"/> Offers a plan that provides one of the following actuarial values(± 2%) : <input type="checkbox"/> Low plan (AV 70%) <input type="checkbox"/> High plan (AV 85%)
Catastrophic Plans	45 CFR §156.155	Standard does NOT apply to stand-alone dental plans. <input type="checkbox"/> If offers a catastrophic plan, it is only offered to eligible individuals eligible to enroll in a catastrophic plan. Eligible individuals: <input type="checkbox"/> Individuals that have not attained the age of 30 before the beginning of the plan year <input type="checkbox"/> Individual has a certification in effect for any plan year exempt from the Shared Responsibility Payment by reason of lack of affordable coverage or hardship. <input type="checkbox"/> If offered, catastrophic plans are offered only in the individual exchange and not in the SHOP. <input type="checkbox"/> If offered, catastrophic plan complies with specific requirements for benefits.
Non-Discrimination	45 CFR §156.125 §156.225(b) §156.200(e)	<input type="checkbox"/> Does not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs. <input type="checkbox"/> Does not discriminate based on individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, other health conditions, race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Passes outlier analysis of QHP cost sharing; information contained in the "explanations" and "exclusions" sections of the plans and benefits template does not include discriminatory practices or wording; issuers have attested to non-discrimination (per Chapter 1, Section 4i of CMS's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from March 1, 2013).
Mental Health Parity and Addiction Equity Act	45 CFR §156.115	Standard does NOT apply to stand-alone dental plans. <input type="checkbox"/> Complies with the Mental Health Parity and Addiction Equity Act.
Meaningful Difference	N/A	Standard does NOT apply to stand-alone dental plans. <input type="checkbox"/> Reflects meaningful difference across product offerings. Chapter 1, Section 4ii of CMS's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from March 1, 2013 clarifies CMS' intent related to this requirement.

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Rates		
Rating Factors	45 CFR §147.102 §156.255	<input type="checkbox"/> Varies rates only based on: <input type="checkbox"/> Geographic area <input type="checkbox"/> Age (3 to 1) <input type="checkbox"/> Tobacco use (1.5 to 1) <input type="checkbox"/> Family composition: <input type="checkbox"/> Individual <input type="checkbox"/> Two-adult families <input type="checkbox"/> One-adult family with child(ren) <input type="checkbox"/> All other families Due to their excepted benefit status, stand-alone dental plans are not required to meet the rating rules of PHS Act section 2701(a) that underlie the QHP Rating Tables and Business Rules template, therefore sections 2.4.1 and 2.4.2 do not apply.
Other Rating Provisions	45 CFR §156.210(a)	<input type="checkbox"/> Sets rates for an entire benefit year, or for the SHOP, plan year.
Other Rating Provisions	45 CFR §156.255(b)	<input type="checkbox"/> Rates must be the same for a QHP offered inside and outside Exchange and without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent.
Other Rating Provisions	45 CFR §155.1020 §156.210(b)	<input type="checkbox"/> Submits rate information to the Exchange at least annually.
Rate Increases	45 CFR §155.1020 §156.210(c) §154.215	<input type="checkbox"/> Submits to the Exchange a justification for a rate increase prior to the implementation of the increase Submits Rate Filing Justification, including: <ul style="list-style-type: none"> • An CMS standardized Unified Rate Review data template (Part I) • Written description justifying the rate increase for increases subject to the review threshold (Part II) Rate filing documentation (Part III), including an actuarial memorandum providing the reasoning and assumptions that support the data submitted in Part I
Rate Increase Posting	45 CFR §155.1020 §156.210(c)	<input type="checkbox"/> Prominently posts the rate increase justification on issuer Web site prior to the implementation of the increase.
Display of Stand-Alone Dental Plan Rates		FOR STAND-ALONE DENTAL ONLY: <input type="checkbox"/> Provides rates and indicates whether they are committing to rates reported or if they are reserving the option to charge additional premium amounts. CMS's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from March 1, 2013.
Accreditation Standards		

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Accreditation	45 CFR §156.275(a)(1)	<p>Standard does NOT apply to stand-alone dental plans.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Accredited on the basis of local performance in the following categories by an accrediting entity recognized by CMS: <input type="checkbox"/> Clinical quality measures, such as the HEDIS <input type="checkbox"/> Patient experience ratings on a standardized CAHPS survey <input type="checkbox"/> Consumer access <input type="checkbox"/> Utilization management <input type="checkbox"/> Quality assurance <input type="checkbox"/> Provider credentialing <input type="checkbox"/> Complaints and appeals <input type="checkbox"/> Network adequacy and access <input type="checkbox"/> Patient information programs
Accreditation Survey Results	45 CFR §156.275(a)(2)	<ul style="list-style-type: none"> <input type="checkbox"/> Authorizes the accrediting entity to release to the Exchange and CMS a copy of its most recent accreditation survey and survey-related information.
Accreditation Timeline	45 CFR §155.1045 45 CFR §156.275(b)	<ul style="list-style-type: none"> <input type="checkbox"/> Accredited within the timeframe established by the Exchange. <input type="checkbox"/> Maintains accreditation. <p>During initial year of certification, issuer must have an existing commercial, Medicaid, or Exchange health plan accreditation in WV granted by an accrediting entity or must have scheduled, or plan to schedule, a review of QHP policies and procedures with the accrediting entity.</p>
Network Adequacy and Provider Directory		<ul style="list-style-type: none"> •
General	45 CFR §156.230	<ul style="list-style-type: none"> <input type="checkbox"/> Complies with WV network adequacy laws and regulations in addition to the specific requirements listed below. <input type="checkbox"/> Has a network for each plan with sufficient number and types of providers to ensure that all services are accessible without unreasonable delay. <p>WV Informational Letter No. 112 provides standards related to distance/time and provider to enrollee ratios.</p> <p>Is accredited on network adequacy and attests to compliance or provides and access plan based on NAIC Model Act #74 Managed Care Plan Network Adequacy.</p>
Essential Community Providers	45 CFR §156.230(a)(1) 45 CFR §156.235	<ul style="list-style-type: none"> <input type="checkbox"/> Has sufficient number and geographic distribution of Essential Community Providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the service area. <ul style="list-style-type: none"> • Issuer achieves at least 20% ECP participation in network in the service area, agrees to offer contracts to at least one ECP of each type available by county, and agrees to offer contracts to all available Indian providers; or • Issuer achieves at least 10% ECP participation in network in the service area, and submits a satisfactory narrative justification as part of its QHP submission; or • Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission.
Mental Health and Substance Abuse Providers	45 CFR §156.230	<ul style="list-style-type: none"> <input type="checkbox"/> Network must include providers that specialize in mental health and substance abuse services.

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		Issuers establish a standard to assure that the QHP network complies with the Federal standard; a copy of this standard is included in application and issuer certifies that the network meets the standard. Standard does NOT apply to stand-alone dental plans.
Service Area	45 CFR §155.1055	<input type="checkbox"/> Has a minimum service area of an entire county.
Provider Directory	45 CFR §156.230(b)	<input type="checkbox"/> Makes its provider directory available: <input type="checkbox"/> To the Exchange for publication online in accordance with guidance from the Exchange <input type="checkbox"/> To potential enrollees in hard copy upon request. <input type="checkbox"/> Provider directory identifies providers that are not accepting new patients. Provides network names, IDs, and URL in a Network Template.
Marketing, Applications, and Notices		
WV Laws	45 CFR §156.225(a)	<input type="checkbox"/> Complies with all WV marketing laws & regulations. <input type="checkbox"/> Certificate of Readability provided WV Legislative Rules Title 114 Series 10; WV 33-29-5
Non-discrimination	45 CFR §156.225(b)	<input type="checkbox"/> Marketing practices do not discourage the enrollment of individuals with significant health needs.
Readability/Accessibility	45 CFR §155.230(b)	<input type="checkbox"/> Provides applications and notices to applicants and enrollees all applications and other material: <input type="checkbox"/> In plain language <input type="checkbox"/> In a manner that is accessible and timely to: <input type="checkbox"/> Individuals living with disabilities <input type="checkbox"/> Individuals with limited English proficiency through the provision of language services at no cost to the individual.
Quality Standards		
Quality	45 CFR §156.200 (b)(5) ACA § 1311(c)(1), 1311(c)(3), 1311(c)(4), and 1311(g)	<input type="checkbox"/> Attests to comply with future Federal rule-making related to 45 CFR §156.200(b)(5). CMS indicates they intend to address specific requirements in future rulemaking related to quality data reporting, quality improvement strategies, and enrollee satisfaction surveys described in these statutory provisions.
Segregation of Funds for Abortion Services		
Abortion Services	45 CFR §156.280 ACA §1303	<input type="checkbox"/> Does not use federal funds for abortion. <input type="checkbox"/> Complies with procedures to ensure Federal funds are not misused, depositing payments into separate allocation accounts. <input type="checkbox"/> Submits segregation plan. <input type="checkbox"/> Provides annual assurance statement. <input type="checkbox"/> If provides for coverage of abortion services, provides a notice to enrollees as part of the summary of benefits and coverage explanation at the time of enrollment. <input type="checkbox"/> Does not discriminate against any health care provider or any health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortion.
<i>Issuers will be required to attest to the Federal requirements included in the following sections.</i>		

**West Virginia Offices of the Insurance Commissioner
QHP REVIEW REQUIREMENTS CHECKLIST**

GROUP MARKET

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Transparency Requirements		
Coverage Transparency	45 CFR §155.1040 45 CFR §156.220	<input type="checkbox"/> Makes available to the public, Exchange, CMS, and the WV Insurance Commissioner in an accurate and timely manner, and in plain language: <input type="checkbox"/> Claims payment policies and practices <input type="checkbox"/> Periodic financial disclosures <input type="checkbox"/> Data on enrollment <input type="checkbox"/> Data on disenrollment <input type="checkbox"/> Data on the number of claims that are denied <input type="checkbox"/> Data on rating practices <input type="checkbox"/> Information on cost-sharing and payments for out-of network coverage <input type="checkbox"/> Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights)
Enrollee Cost-Sharing	45 CFR § 156.220(d)	<input type="checkbox"/> Makes available the amount of enrollee cost-sharing for a specific item or service by a participating provider in a timely manner upon the request of the individual. <input type="checkbox"/> Makes available such information through: <input type="checkbox"/> Internet website <input type="checkbox"/> Other means for individuals without access to the Internet
Appeals Notices	45 CFR §147.136(e)	<input type="checkbox"/> Provides required notices on internal and external appeals in a culturally and linguistically appropriate manner.
Enrollment Periods		
Initial	45 CFR §155.410(b)	<input type="checkbox"/> Provides an initial open enrollment period October 1, 2013 to March 31, 2014.
Annual		
Special	45 CFR §155.420	<input type="checkbox"/> Provides special enrollment periods for qualified enrollees. <input type="checkbox"/> Provides notice to individuals eligible to enroll during a special enrollment period.
Enrollment Process for Qualified Individuals		
Enrollment	45 CFR §156.265 (b)(1) 45 CFR §156.265 (b)(2) 45 CFR §156.265 (c) 45 CFR §156.265 (d) 45 CFR §156.265 (e) 45 CFR §156.265 (f)45 CFR §156.400 (d) 45 CFR §156.265 (g)	<input type="checkbox"/> Enrolls a qualified individual when Exchange notifies the issuer that the individual is a qualified individual and transmits information to the issuer. <input type="checkbox"/> If an applicant initiates enrollment directly with the issuer for enrollment through the Exchange, the issuer either: <input type="checkbox"/> Directs the individual to file an application with the Exchange <input type="checkbox"/> Ensures that the individual received an eligibility determination for coverage through the Exchange via the Exchange Internet website. <input type="checkbox"/> Accepts enrollment information consistent with the privacy and security requirements established by the Exchange. <input type="checkbox"/> Uses the premium payment process established by the Exchange. <input type="checkbox"/> Provides new enrollees an enrollment information package that is compliant with accessibility and readability standards. <input type="checkbox"/> Reconciles enrollment files with CMS and the Exchange no less than once a month. <input type="checkbox"/> Acknowledges receipt of enrollment information transmitted from the Exchange in accordance with Exchange standards.
Termination of Coverage of Qualified Individuals		
Termination Allowances	45 CFR §155.430(b)	Terminates coverage only if:

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	45 CFR §156.270	<input type="checkbox"/> Enrollee is no longer eligible for coverage through the Exchange <input type="checkbox"/> Enrollee's coverage is rescinded <input type="checkbox"/> QHP terminates or is decertified <input type="checkbox"/> Enrollee switches coverage: <input type="checkbox"/> During an annual open enrollment period <input type="checkbox"/> Special enrollment period <input type="checkbox"/> Obtains other minimum essential coverage <input type="checkbox"/> For non-payment of premium only if: <input type="checkbox"/> Applies termination policy for non-payment of premium uniformly to enrollees in similar circumstances <input type="checkbox"/> Enrollee is delinquent on premium payment <input type="checkbox"/> Provides the enrollee with notice of such payment delinquency <input type="checkbox"/> Provides a grace period of at least three consecutive months if an enrollee is receiving advance payments of the premium tax credit and has previously paid at least one month's premium
Notice	45 CFR §155.430 (d)45 CFR §156.270 (b)	<input type="checkbox"/> Provides reasonable notice of termination of coverage to the Exchange and enrollee (this includes effective date of termination).
Records	45 CFR §155.430(c) 45 CFR §156.270(h)	<input type="checkbox"/> Maintains records of terminations of coverage for auditing.
SHOP-Specific Requirements	45 CFR §156.285	
		<input type="checkbox"/> Accepts payment from the SHOP on behalf of a qualified employer or employee. <input type="checkbox"/> Adheres to the SHOP timeline for rate setting. <input type="checkbox"/> Charges the same contact rate for a plan year.
		<input type="checkbox"/> Adheres to the SHOP enrollment timeline and process. <input type="checkbox"/> Receives enrollment information electronically. <input type="checkbox"/> Provides new enrollees with an enrollment information package. <input type="checkbox"/> Reconciles enrollment files with the SHOP at least monthly. <input type="checkbox"/> Acknowledges receipt of enrollment information in accordance with SHOP standards. <input type="checkbox"/> Enrolls all qualified employees consistent with the employer's plan year. <input type="checkbox"/> Enrolls a qualified employee in accordance with the qualified employer's annual open enrollment period. <input type="checkbox"/> Provides special enrollment periods. <input type="checkbox"/> Provides an enrollment period for an employee who becomes a qualified employee outside of the initial or annual open enrollment period. <input type="checkbox"/> Adheres to effective dates of coverage.
		<input type="checkbox"/> Complies with requirements with respect to termination of employees.
		<input type="checkbox"/> If a qualified employer withdraws from the SHOP, terminates coverage for all enrollees of the withdrawing employer.
Recertification and Decertification		
Recertification	45 CFR §156.290	<input type="checkbox"/> If elects not to seek recertification with the FFE: <input type="checkbox"/> Notifies the FFE of its decision prior to the beginning of the recertification process and procedures adopted by the FFE <input type="checkbox"/> Fulfills its obligation to cover benefits for each enrollee through the end of the plan or benefit year <input type="checkbox"/> Fulfills data reporting obligations from the last plan or benefit year of the certification <input type="checkbox"/> Provides written notice to enrollees <input type="checkbox"/> Terminates coverage for enrollees in the QHP.
Decertification	45 CFR §156.290	<input type="checkbox"/> If decertified by the FFE, terminates coverage for enrollees only after:

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QHP REVIEW REQUIREMENTS CHECKLIST**

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REVIEW REQUIREMENTS	REFERENCE	COMMENTS
		<input type="checkbox"/> The FFE has made notification <input type="checkbox"/> Enrollees have an opportunity to enroll in other coverage
Other Substantive and Reporting Requirements		
General Compliance	45 CFR §156.200(b)(2)	<input type="checkbox"/> Complies with all Exchange processes, procedures, requirements.
User Fee	45 CFR §156.200(b)(6)	<input type="checkbox"/> Pays the Exchange user fee.
Risk Adjustment	45 CFR §156.200(b)(7)	<input type="checkbox"/> Complies with risk adjustment program.
Non-Discrimination	45 CFR §156.200(e)	<input type="checkbox"/> Does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.
Consumer Interest	45 CFR §155.1000(c)(2)	<input type="checkbox"/> Is in the interest of qualified individuals.
Claims, Appeals, and External Review	45 CFR §147.136	<input type="checkbox"/> Complies with internal claims and appeals and external review process.
Direct Primary Medical Home	45 CFR §156.245	<input type="checkbox"/> If provides coverage through a direct primary care medical home: <input type="checkbox"/> Medical home meets criteria established by CMS <input type="checkbox"/> Issuer meets all requirements otherwise required <input type="checkbox"/> Issuer coordinates the services covered by the direct primary care medical home
Data-Sharing		<input type="checkbox"/> Collects and transmits data to and from Exchanges, CMS, Treasury, and reinsurance entities. <input type="checkbox"/> Provides a description of system infrastructure's capacity to securely interface with these entities for data transfers, including enrollment, reconciliation, claims encounter data, and reports.
Prescription Drug Distribution and Cost Reporting	45 CFR §156.295	<input type="checkbox"/> Reports to U.S. DCMS on prescription drug distribution and cost the following information (paid by PBM or issuer): <input type="checkbox"/> Percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies <input type="checkbox"/> Percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type: <input type="checkbox"/> Independent pharmacy <input type="checkbox"/> Supermarket pharmacy <input type="checkbox"/> Mass merchandiser pharmacy <input type="checkbox"/> Aggregate amount and type of rebates, discounts, or price concessions that the issuer or its contracted PBM negotiates that are: <input type="checkbox"/> Attributable to patient utilization <input type="checkbox"/> Passed through to the issuer <input type="checkbox"/> Total number of prescriptions that were dispensed. <input type="checkbox"/> Aggregate amount of the difference between the amount the issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies.