

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

**INDIVIDUAL MARKET**

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
<b>State Requirements</b>		
<i>All references are State of West Virginia statute and regulations, unless otherwise noted</i>		
<b>FORMS</b>		
<b>General Requirements</b>		SERFF filings are submitted in accordance with SERFF filing requirements.
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. Review within 60 days.  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.
Prohibited Provision Or Practice	§33-6-14 §33-4-20(b)(3)	The policy must be construed under the laws of this state. No entity providing life or health insurance may deny, refuse to issue, refuse to reissue, cancel or otherwise terminate an insurance policy or restrict coverage on any individual because that individual is, has been or may be the victim of abuse.
Policy Contents	§ 33-6-11	The policy shall specify the names of the parties to the contract, the insurer's name, the subject of the insurance, the risks insured against, the time the insurance coverage becomes effective and the term during which such coverage continues, the premium (or sufficient information to determine the premium), and the conditions pertaining to the insurance.
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.
Execution of Policies	§33-6-15	Every insurance policy shall be executed in the name of and on behalf of the insurer by its officer, attorney-in-fact, employee, or representative duly authorized by the insurer. A facsimile signature of any such executing individual may be used in lieu of an original signature, except that in all policies other than those approved for machine vending the countersignature shall be in original handwriting.
Compliance	§33-15 §33-15A Reg. 114-10 Reg. 114-17	<u>The Certification of Compliance</u> should reference the Chapter and Article for Individual Accident and Sickness policies. <u>Individual Accident and Sickness</u> policy forms must comply with Chapter 33, Article 15 of the WV Code. <u>Advertising</u> - Department policy to require advertising filing on all Accident & Sickness products. <u>AIDS Regulation</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.
<b>Required Disclosure Provisions</b>		
Insuring Clause	§33-6-11	<u>On the First Page</u> of the health policy, there should be a broad statement stipulating the conditions under which benefits are to be paid for losses resulting from sickness or accidents. This is the <u>insuring agreement</u> .
Free Look Provision (Right of Return)	Reg. §114-12-6.6.8	<u>On the First Page</u> of all policies, there must be a prominently displayed notice, stating that the policyholder has the <u>right to return the policy within 10 days</u> of its delivery and to have the premium refunded if after examination of the policy the policyholder is not satisfied for any reason.
Definition of Special Terms	Reg. §114-12-6.6.4	A policy which provides for the payment of benefits based on standards described as usual and customary, reasonable and

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		customary, or similar words must include a definition of those terms in both the policy and the Outline of Coverage.
Summary of Benefit Coverage (SBC)	PHSA 2715 (PPACA)	No policy or certificate for individual health insurance may be delivered or issued for delivery in West Virginia unless an <u>Summary of Benefit Coverage (SBC)</u> is completed for that policy. The SBC and glossary will be provided with enrollment materials or generally 30 days prior to the start of coverage if enrollment materials are not distributed. Consumers in all markets may request a copy of their SBC at any time, and plans and issuers will be required to provide it within 7 business days. The SBC will contain a link to the uniform glossary, but plans and issuers will be required to provide paper copies within 7 business days of requests. Plans and issuers will also provide a notice of material modifications 60 days prior to the effective date of such modifications.
Form and Content Requirements For Accident & Sickness Policies	§33-15-2	<u>Form and Content Requirements</u> - (a) The entire money and considerations must be expressed; (b) The effective date and the termination date of the policy must be expressed; (c) The policy purports to insure only one person, except for family members of the adult policyholder; (d) The policy is guaranteed renewable at the option of the insured; (e) Specifications for style, arrangement, over-all appearance, print size must be met; (f) Each policy form, including riders and endorsements must be identified by a form number in the lower left hand corner of the first part. . . (each page preferably); (g) There must be no provision purporting to make any portion of the insurer's charter, rules, constitution, by-laws a part of the policy. . . (h) The insurer must offer and accept for enrollment every eligible individual who applies for coverage within 63 days after termination of the individual's prior creditable coverage.
<b>Required Policy Provisions</b>		
(1) Entire Contract	§33-15-4(a)	<u>Entire Contract</u> – The Entire Contract includes the policy, all endorsements and any attached papers, such as the application and any riders. Nothing outside of the contract and its attachments is considered part of the entire contract. This Entire Contract assures the policy owner that no changes will be made to the contract after it has been issued. Only an executive Officer of the insurance company and not the agent can make changes to the policy.
(2) Time Limit on Certain Defenses	§33-15-4(b)	<u>Time Limit on Certain Defenses</u> – There is a limit to the period of time in which an insurer may challenge the contract or deny a claim on grounds of material misrepresentation in the application. There are two provisions: 1) After two (2) years has expired from the policy date of issue, no material non disclosures or misstatements made by the applicant may be used to void the policy or deny a claim except in case of fraudulent misstatements. 2) After two (2) years has expired, the insurer cannot deny a claim on the basis of preexisting conditions, unless the condition was excluded from coverage under the policy by name or specific description.
(3) Grace Period	§33-15-4(c)	<u>Grace Period</u> – A certain number of days are allowed after the premium due date during which a premium may be paid without penalty or lapse of the policy for non-payment of premium. The number of days depends on how the premiums are paid: a) 7 days if premiums are paid weekly; b) 10 days if premiums are paid monthly; c) 31 days for all other modes of premium payment.
(5) Reinstatement	§33-15-4(d)	<u>Reinstatement</u> – A policy which has lapsed due to non payment of premium may be put back in force. a) If an application is required, and a conditional receipt for the premium is issued, the policy will be reinstated upon the insurer's approval of the application, or lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the applicant in writing of the disapproval of such application.
(6) Notice of Claim	§33-15-4(e)	<u>Notice of Claim</u> – A Policyholder must give the insurer written notice of claim within 20 days or as soon as reasonably possible. This notice can be given to either the agent or directly to the insurance company. In loss of time contracts, notice of continuation of disability is required at least every six months except in the absence of legal incapacity.
(7) Claim Forms	§33-15-4(f)	<u>Claim Forms</u> - Upon receipt of a notice of claim, the insurer will furnish the claimant within fifteen (15) days the appropriate forms upon which the claimant is to file proofs of loss. The proof of loss must cover the occurrence, the character and the extent of the loss for which claim is made.

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(8) Proof of Loss	§33-15-4(g)	<u>Proof of Loss</u> – The claimant must provide the insurer with the written proof of loss within 90 days of the loss or, in the case of a continuing loss, within 90 days after the end of a period for which the insurer is liable. A proof of loss is a formal statement given to the carrier regarding the loss. If the claimant is unable to file within 90 days, the proof of loss must be filed within a reasonable time not exceeding one year, except in the case of legal incapacity.
(10) Payment of Claims	§33-15-4(l)	<u>Payment of Claims</u> – Death benefits from any group policy or individual accident policy are paid to a named beneficiary otherwise to the estate of the insured. If the beneficiary is a minor or legally incapable of receiving proceeds, a facility of payment provision may be included for payments up to one thousand dollars (\$1,000.00). All other benefits are payable to the insured unless assigned to a healthcare provider. The insurer may have the option of making payments directly to the person or hospital rendering services.
(11) Physical Exams & Autopsy	§33-15-4(j)	<u>Physical Examinations and Autopsy</u> – The insurer at its own expense has the right to examine the person insured when and as often as it is reasonably required while a claim under the policy is pending and to make an autopsy in case of death where it is not prohibited by law.
(12) Legal Actions	§33-15-4(k)	<u>Legal Actions</u> – No legal action shall be brought against the company prior to sixty (60) days after proof of loss has been submitted and not later than three years after proof of loss has been submitted.
(13) Change of Beneficiary	§33-15-4(l)	<u>Change of Beneficiary</u> – Unless the insured makes an irrevocable designation of beneficiary, the insured has the right to change the beneficiary and the consent of the beneficiary is not required for the surrender or assignment or other changes in this policy.
AIDS Regulation	Reg. §114-27-2.2.1  Reg. §114-27-4.4.1 b -4.4.2 a -4.4.2 b  -4.4.2 c	All insurers who deliver or issue for delivery in this state any policies for life or accident and sickness insurance are subject to this regulation.  Sexual orientation may not be used in the underwriting process or in the determination of insurability. No question shall be used which is designed to establish the sexual orientation of the proposed insured. Questions relating to the proposed insured having or having been diagnosed as having AIDS or ARC are permissible if they are factual and designed to establish the existence of the condition. Questions inquiring as to whether the proposed insured has ever tested positive for the presence of the HIV virus or HIV virus antibodies are permissible; however, questions inquiring as to whether the proposed insured has ever been tested for the presence of the HIV virus or HIV antibodies are prohibited.
<b>Mandatory Benefits</b>		
Mental Illness Coverage	45 CFR §156.115	<u>Mental Illness Coverage</u> – EHB covered under Mental health and substance use disorder services, including behavioral health treatment.
Nursing Services	§33-15-4b	<u>Nursing Services</u> – Any insurer issuing policies of accident and sickness insurance shall make available to all subscribers and member’s coverage for primary health care nursing services as described in Article 4b (a), (b) and (c).
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 Therapy Benefits	§33-15-4d	<u>Rehabilitation Therapy Benefits</u> – Any entity regulated by Article 15 of Chapter 33 shall provide benefits to all subscribers and members for coverage for rehabilitation services. “Rehabilitation Services” includes those services designed to remediate patient’s condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status. These services include, but are not limited to, diagnostic testing, assessment, monitoring or treatment of conditions as described in 33-15-4d (b), (c) and (d). . . Stroke; Spinal cord injury; Amputation; Brain injury. . .
Postpartum Hospital Stay Coverage	§33-15-4e	An insurer offering accident and sickness coverage under Article 15 may not restrict the mother or her newborn child to less than forty-eight hours following a normal vaginal delivery, or to less than ninety-six hours following a cesarean section. . . The mother and her newborn child may be discharged prior to the expiration of the minimum length of stay in those cases in which the decision to discharge is made by an attending provider in consultation with the mother.
Colorectal Cancer Screening Coverage	§33-15-4f	When reimbursement or indemnity for laboratory or X-ray services are covered under the policy and are performed by qualified and medical board certified physicians, reimbursement or indemnification for colorectal cancer examinations and

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		laboratory testing may not be denied for any nonsymptomatic person fifty years of age or older, or a symptomatic person under fifty years of age.
TMJ / CMD	§33-16-3f Reg. §114-29-4	All insurers who issue for delivery in this state accident and sickness insurance policies shall provide benefits for the diagnosis and treatment of temporomandibular disorders (TMD) and craniomandibular disorders. This applies to both renewed coverage and new coverage. 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 into the insurance policy or other evidence of coverage.
Reconstructive Surgery Following Mastectomy	§33-15-4g	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	§33-15-4h	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 15 of Chapter 33.
Third-party reimbursement for kidney disease screening	§33-15-4i	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	§33-15-4j	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

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		<p>may not be construed to require coverage for the dental care for which the general anesthesia is provided.</p> <p>(f) Temporal mandibular joint disorders. -- The provisions of this section do not apply to dental care rendered for temporal mandibular joint disorders.</p> <p>(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.</p>
Child Immunization Services Coverage	§33-15-17	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.
Emergency Services	§33-15-21	<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. 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>
Contraceptive Coverage (Applies to policies which include a prescription drug plan)	§33-16E-3	Health insurance plans that provide benefits for prescription drugs or prescription devices in prescription drug plans may not exclude or restrict benefits to covered persons for any prescription contraceptive drug or prescription contraceptive device approved by the federal Food and Drug Administration.
Diabetes Coverage	§33-15C-1	<p>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.</p> <p>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.</p> <p>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.</p> <p>Any deductible or coinsurance billed for any service shall apply on an equal basis with all other coverages provided by the insurer.</p>
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 after the date of birth in order to have the coverage continue beyond such 31 day period.

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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.
<b>Optional Policy Provisions Individual Accident and Sickness Policies</b>		
Misstatement of Age	§33-15-5(b)	" <u>Misstatement of Age</u> " – Caption the provision. "If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age."
Other Insurance with this Insurer	§33-15-5(c)	" <u>Other Insurance With This Insurer</u> " – Caption the provision. This provision is designed to limit the problems of over-insurance. 1) If a policy or policies concurrently in force, issued by and insurer to an insured, make(s) the aggregate indemnity for the accident and sickness coverages excess of a maximum stated limit, the excess insurance shall be void and all premiums paid shall be returned to the insured. 2) The Liability of the insurer is limited to one policy selected by the insured and premiums for all others shall be refunded.
Insurance with Other Insurers	§33-15-5(d)	" <u>Insurance With Other Insurers</u> " – Caption the provision. The essence of this provision: If an insured person has two or more policies that cover the same expenses with more than one insurer and the insurers were not notified that the other coverage existed, then each company shall pay a proportionate share of any claim. Each insurer's share of the claim shall be in proportion to the amount of the insurer's coverage involved in the claim. (This prevents the insured from receiving benefits greater than the loss.) The insurer may include in this provision a definition for "other valid coverage". Provision shall be made for the return of such portion of the premium paid as shall exceed the amount needed to pay for the company's portion of prorated benefits.
Unpaid Premiums	§33-15-5(f)	" <u>Unpaid Premiums</u> " – Caption the provision. If there is an unpaid premium or a premium is covered by a note at the time a claim becomes payable, the amount of the premium shall be deducted from the sum payable to the insured or to the beneficiary.
Return of Premium on Cancellation	§33-15-5(g)	" <u>Return of Premium on Cancellation</u> " - After the initial term, the insured may cancel at any time with written notice to the company. If the insured cancels this policy, the earned premium shall be computed by the use of the short-rate table last filed with the Insurance Commission. Cancellation is effective upon the company's receipt of the written notice, but does not affect claims pending to the effective date of cancellation. The insurer is allowed to cancel the policy with written notice to the insured during the initial term. If the insurer cancels the policy, any unearned premium is refunded on a pro rata basis. The insurer must give the insured (7) days notice if the premium is paid weekly; (10) days notice if the premium is paid monthly; (31) days notice for any other mode of payment.
Conformity with State Statutes	§33-15-5(h)	" <u>Conformity with State Statutes</u> " – Caption the provision. "Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes."
(9) Illegal Occupation	§33-15-5(l)	" <u>Illegal Occupation</u> " – Caption the provision. "The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation."
(10) Intoxicants and Narcotics	§33-15-5(j)	" <u>Intoxicants and Narcotics</u> " – Caption the provision. "The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician."
Advertising	Reg. 114-10 (1-20) §114-10-5  Reg. §114-10-6	Standards – (- 5.1 a ) - The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. (-5.1 b) – Advertisements shall be truthful and not misleading in fact or implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used. Advertisements of Benefits Payable, Losses Covered or Premiums Payable - (a) No advertisement shall omit information or use words, phrases, statements references or illustrations if the omission of such information or use of such words,

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		phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. (b) No advertisement shall contain or use words or phrases such as, "All," "Full," "Complete," "Comprehensive;" "Unlimited;" "Up To;" "As High As;" . . . or similar words or phrases, in a manner which exaggerates any benefits beyond the terms of the policy.
<b>Unique Characteristics of Health Insurance Contracts</b>		
Conditional		The contract is Conditional in that the obligation of the insurance company to pay a claim depends on the insure performing certain acts such as, payment of premiums, notifying the company of a claim (within 20 days), filing claim reports (proof of loss), etc.
Unilateral		The contract is Unilateral because it involves the enforceable promises of only one party, the insurer. In order for the contract to perform, the insured must pay the premium, although the contract does not obligate him to do so. If the insured does pay the premiums as required, the company must accept them and meet its full obligation under the contract.
Adhesion		The health insurance contract is a contract of Adhesion because all the provision are determined by the insurance company. The applicant has a right to accept or reject the contract; it is not the result of negotiation between the two parties. Since the insured accepts the contract, any ambiguities are usually interpreted in favor of the insured by the courts.
<b>Common Exclusions or Restrictions</b>		
Policy Exclusions		Some common exclusions found in health insurance policies include: injuries due to war or an act of war, self-inflicted injuries, injuries incurred while the insured serves as a pilot or crew member of an aircraft. Other exclusions are losses resulting from suicide, riots or the use of drugs or narcotics. (This department does not permit the exclusion of hernia, as an accidental injury.) Losses due to injuries sustained while committing or attempting to commit a felony, may be excluded. Foreign travel may not be excluded in every instance and extended stays may cause a loss of benefits. If travel to specific countries is excluded, a list of the countries must be provided the insured, prior to purchase. Terrorism is excluded.
<b>Replacement of Health Insurance</b>	<b>Reg. §114-12-7</b>	
<b>The Application</b>	Reg. §114-12-7.7.1	The Application forms must include a question designed to elicit information as to whether the policy to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application to be signed by the applicant containing such question may be used.
<b>Rights of Renewability</b>		
Newly Born Children	§33-6-32	All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or subscriber shall, as to such family members coverage, also 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. For the newly born child there shall be coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the policy may require that notice of the newborn child's birth and payment of the required premium must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days in order to have the coverage continue beyond the 31-day period.
<b>Service Corporations</b>		
Hospital Service Corporation	§33-24-2 (b)	<u>Hospital Service Corporation</u> is a non-profit, non-stock corporation, organized for the sole purpose of contracting with the public and with hospitals and other health agencies for hospital or other health services to be furnished to subscribers

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		under terms of their contract with the corporation. The corporation must have a controlling board of directors (not more than 20% of whom, or whose spouse, parent, child, brother or sister by blood or marriage) who are engaged in the providing of health care, and at least 80% of whom must be chosen as representatives of the interests of consumers, elderly persons, organized labor and business subscribers.
Medical Service Corporation	§33-24-2 (d)	<u>Medical Service Corporation</u> is a nonprofit, non-stock corporation, organized for the sole purpose of contracting with the public and with licensed physicians, dentists and podiatrists for medical or surgical services and with licensed chiropractors and other health agencies for other health services to be furnished to subscribers under terms of their contract with the corporation. The corporation must have a controlling board of directors (not more than 20% of whom, or whose spouse, parent, child, brother or sister by blood or marriage) who are engaged in the providing of health care, and at least 80% of whom must be chosen as representatives of the interest of consumers, elderly persons, organized labor and business subscribers.
Dental Service Corporation	§33-24-2 (f)	<u>A Dental Service Corporation</u> is a nonprofit, non-stock corporation, organized for the sole purpose of contracting with the public and with licensed dentists for dental services to be furnished to subscribers under terms of their contracts with the corporations. The corporation must have a board of directors as discussed with the previous corporation forms.
Health Service Corporation	§33-24-2 (h)	<u>A Health Service Corporation</u> is a nonprofit, non-stock corporation, organized for the sole purpose of contracting with the public and with hospitals and other health agencies for hospital or other health services to be furnished to subscribers, or for the purpose of contracting with the public and with licensed physicians, dentists and chiropodists-podiatrists for medical or surgical services and with chiropractors and other health agencies for other health services or for the purpose of contracting with the public and with duly licensed dentists for dental services to be furnished to subscribers, all under terms of their contract or contracts with the corporation. Must have a board of directors as previously described. Hospital Service, Medical Service and Dental Service Corporations may merge to form a Health Service Corporation. However, no merger may be made unless the plan, agreement and other supporting documents have been filed in advance and approved by the Insurance Commissioner. Examinations of such corporations are conducted by the Commissioner once every four years.
PPACA FILINGS		Please refer to documentation in SERFF's Online Help section for instructions on completing the required PPACA fields. West Virginia <u>does</u> accept grandfathered and non-grandfathered related filings in one submission.
<b>Federal Requirements</b>		
<i>All references are Federal statute and regulations, unless otherwise noted</i>		
<b>Issuer Administrative Information</b>	N/A	Please see Administrative Data Template for details on information requested.
<b>Licensure, Solvency, and Standing</b>		
<b>Licensure and Solvency</b>	45 CFR § 156.200(b)(4)	<input type="checkbox"/> Is licensed or authorized in WV to offer health insurance; or <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).
<b>Benefit Standards and Product Offerings</b>		

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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"> <li><input type="checkbox"/> Ambulatory patient services</li> <li><input type="checkbox"/> Emergency services</li> <li><input type="checkbox"/> Hospitalization</li> <li><input type="checkbox"/> Maternity and newborn care</li> <li><input type="checkbox"/> Mental health and substance use disorder services, including behavioral health treatment</li> <li><input type="checkbox"/> Prescription drugs</li> <li><input type="checkbox"/> Rehabilitative and habilitative services and devices</li> <li><input type="checkbox"/> Laboratory services</li> <li><input type="checkbox"/> Preventive and wellness services and chronic disease management</li> <li><input type="checkbox"/> Pediatric services, including oral and vision care.</li> </ul> <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	45 CFR §156.130 45 CFR §156.150 (for SADPs)	<input type="checkbox"/> Complies with annual limitation on cost-sharing. <input type="checkbox"/> Cost-sharing shall not exceed the dollar amounts in effect under §223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage. <input type="checkbox"/> Complies with requirements related to coverage of out-of-network emergency services.  FOR SHOP ONLY: <input type="checkbox"/> Complies with annual limitations on deductibles for employer-sponsored plans.  FOR STAND-ALONE DENTAL ONLY: <input type="checkbox"/> Cost-sharing is "reasonable" for coverage of the pediatric dental EHB.  CMS's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from April 5, 2013 clarified that for the 2014 coverage year in the FFE, CMS interprets the word "reasonable" to mean any annual limit on cost sharing that is at or below \$700 for a plan with one child enrollee or \$1,400 for a plan with two or more child enrollees.
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%): <ul style="list-style-type: none"> <li><input type="checkbox"/> Bronze plan (AV 60%)</li> <li><input type="checkbox"/> Silver plan (AV 70%)</li> <li><input type="checkbox"/> Gold plan (AV 80%)</li> <li><input type="checkbox"/> Platinum plan (AV 90%)</li> <li><input type="checkbox"/> Catastrophic plan</li> </ul>

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		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 April 5, 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 April 5, 2013 clarifies CMS’ intent related to this requirement.
<b>Rates</b>		
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.

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<b>Other Rating Provisions</b>	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"> <li>• An CMS standardized Unified Rate Review data template (Part I)</li> <li>• Written description justifying the rate increase for increases subject to the review threshold (Part II)</li> </ul> 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 April 5, 2013.
<b>Accreditation Standards</b>		
Accreditation	45 CFR §156.275(a)(1)	Standard does NOT apply to stand-alone dental plans.  <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)	<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)	<input type="checkbox"/> Accredited within the timeframe established by the Exchange.  <input type="checkbox"/> Maintains accreditation.  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.
<b>Network Adequacy and Provider</b>		

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<b>Directory</b>		
General	45 CFR §156.230	<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.  WV Informational Letter No. 112 provides standards related to distance/time and provider to enrollee ratios.  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.
Essential Community Providers	45 CFR §156.230(a)(1) 45 CFR §156.235	<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"> <li>• 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</li> <li>• 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</li> <li>• Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission.</li> </ul>
Mental Health and Substance Abuse Providers	45 CFR §156.230	<input type="checkbox"/> Network must include providers that specialize in mental health and substance abuse services.  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.
<b>Marketing, Applications, and Notices</b>		
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:

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		<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.
<b>Quality Standards</b>		
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.
<b>Segregation of Funds for Abortion Services</b>		
Abortion Services	45 CFR §156.280 ACA §1303	Standard does NOT apply to stand-alone dental plans.  <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.
<ul style="list-style-type: none"> <li>• Issuers will be required to attest to the Federal requirements included in the following sections.</li> </ul>		
<b>Transparency Requirements</b>		
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.
<b>Enrollment Periods</b>		
Initial	45 CFR §155.410(b)	<input type="checkbox"/> Provides an initial open enrollment period October 1, 2013 to March 31, 2014.
Annual	45 CFR §155.410(e)	<input type="checkbox"/> Provides an annual open enrollment period October 15 to December 7.

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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.
<b>Enrollment Process for Qualified Individuals</b>		
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.
<b>Termination of Coverage of Qualified Individuals</b>		
Termination Allowances	45 CFR §155.430(b) 45 CFR §156.270	Terminates coverage only if: <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.
<b>Recertification and Decertification</b>		
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

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		<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: <input type="checkbox"/> The FFE has made notification <input type="checkbox"/> Enrollees have an opportunity to enroll in other coverage
<b>Other Substantive and Reporting Requirements</b>		
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.