West Virginia Offices of the Insurance Commissioner
REVIEW REQUIREMENTS CHECKLIST

GROUP ACCIDENT & SICKNESS INSURANCE

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
FORMS		
GENERAL REQUIREMENTS		
Fees	§33-6-34	The fee for a Form Filing is $100.00 per Filing, regardless of the number of forms.
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 33-16A 114-10 114-24 114-26 114-27 114-28 114-29 PPACA	Group Accident and Sickness policy forms must comply with Chapter 16 of the WV Code. The Required provisions are found in 33-16-3. Group Health – Conversions: This Chapter sets forth the requirements for group policy conversions. Advertising – Department policy to require advertising filing on all Accident & Sickness products. Medicare Supplements Rate Filing Accident and Sickness AIDS Regulation Coordination of Benefits Temporo/Craniomandibular Disorders Groups must comply with the provisions of the PPACA or be exempted.
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)
Conversion Clause		Permits an individual insured under the group plan to convert to individual coverage upon termination of employment or membership in the group (usually within 31 days of termination). The individual must have participated in the group plan for a given period of time before the conversion privilege applies.
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		
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. (2) A policy issued to an association or to a trust or to the trustees of a fund established, created or maintained for the benefit of members of one or more associations. The association or associations shall have at the issuance of the policy a minimum of one hundred persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least one year; and shall have a constitution and bylaws that provide that: The association or associations hold regular meetings not less than annually to further the purposes of the members; except for credit unions, the association or associations collect dues or solicit contributions from members; and the members have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements: (A) The policy may insure members of the association or associations, employees thereof or employees of members or one or more of the preceding or all of any class or classes for the benefit of persons other than the employee's employer. (B) The premium for the policy shall be paid from: (i) Funds contributed by the association or associations; (ii) Funds contributed by covered employer members; (iii) Funds contributed by both covered employer members and the association or associations; (iv) Funds contributed by the covered persons; or (v) Funds contributed by both the covered persons and the association, associations or employer members. (C) Except as provided in paragraph (D) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject coverage in writing. (D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer. (E) A small employer, as defined in subdivision (r), section two, article sixteen-d of this chapter, insured under an eligible group policy provided in this subdivision shall also be subject to the marketing and rate practices provisions in article sixteen-d of this chapter. (3) A policy issued to a bona fide association; (4) A policy issued to a college, school or other institution of learning or to the head or principal thereof, insuring at least ten students, or students and employees, of the institution; (5) A policy issued to or in the name of any volunteer fire department, insuring all of the members of the department or all of any class or classes thereof against any one or more of the hazards to which they are exposed by reason of the membership but in each case not less than ten members; (6) A policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state, to insure any class or classes of individuals that could be insured under the group life policy; and (7) A policy issued to cover any other substantially similar group which in the discretion of the commissioner may be subject to the issuance of a group accident and sickness policy or contract.
Discipline	§30-3-14	Nothing in this article shall prohibit disciplinary action or criminal prosecution of a prescriber for: o Failing to maintain complete, accurate, and current records documenting the physical examination and medical history of the patient, the basis for the clinical diagnosis of the patient, and the treatment plan for the patient; o Writing a false or fictitious prescription for a controlled substance scheduled in §60A-2-201 et seq. of this code; or

		○ Prescribing, administering, or dispensing a controlled substance in violation of the provisions of the federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§801, et seq. or chapter §60A-1-101 et seq. of this code; ○ Diverting controlled substances prescribed for a patient to the physician's own personal use or ○ Abnormal or unusual prescribing or dispensing patterns, or both as identified by the Controlled Substance Monitoring Program set forth in §60A-9-1 et seq. of this code. These prescribing and dispensing patterns may be discovered in the report filed with the appropriate board as required by section §60A-9-1 et seq. of this code. Nothing in this article shall prohibit disciplinary action or criminal prosecution of a nurse or pharmacist for: ○ Administering or dispensing a controlled substance in violation of the provisions of the federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§801, et seq. or §60A-1-101 of this code; or ○ Diverting controlled substances prescribed for a patient to the nurse's or pharmacist's own personal use. Upon receipt of the quarterly report set forth in §60A-9-1 et seq. of this code, the licensing board shall notify the prescriber that he or she has been identified as a potentially unusual or abnormal prescriber. The board may take appropriate action, including, but not limited to, an investigation or disciplinary action based upon the findings provided in the report. A licensing board may upon receipt of credible and reliable information independent of the quarterly report as set forth in §60A-9-1 et seq. of this code initiate an investigation into any alleged abnormal prescribing or dispensing practices of a licensee. The licensing boards and prescribers shall have all rights and responsibilities in their practice acts
REQUIRED POLICY PROVISIONS		
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.

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MANDATORY BENEFITS		
Mental Health	§33-16-3a	Must be in parity per MHPEA
Essential Health Benefits	Informational Letter 186	Essential Health Benefits must be covered.
Medicare Supplement Insurance	§33-16-3d, §114-24-5, §114-24-6, §114-24-6A, §114-24-7, §114-24-7A	Standards for Medicare Supplement Insurance are found in §33-16-3d, §114-24-5, §114-24-6, §114-24-6A, §114-24-7, and §114-24-7A .
Pre-Existing Conditions Limitations	§33-16-3k	a health benefit plan issued in connection with a group health plan may not impose a preexisting condition exclusion with respect to an employee or a dependent of an employee for losses incurred by the employee or dependent more than twelve months (or eighteen months for a late enrollee) after the earlier of the individual's date of enrollment in the health benefit plan or the first day of a waiting period for enrollment in the plan.
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.
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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Amino acid-based formulas	§33-16-3bb	A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that is subject to this article shall provide coverage, through the age of 20, for amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state pursuant to either §30-3-1 *et seq*. or §30-14-1 *et seq*. of this code: o Immunoglobulin E and Nonimmunoglobulin E-medicated allergies to multiple food proteins; o Severe food protein-induced enterocolitis syndrome; o Eosinophilic disorders as evidenced by the results of a biopsy; and o Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract (short bowel). The coverage required by §33-24-7q(a) of this code shall include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary, regardless of methodology of delivery. For purposes of this section, "medically necessary foods" or "medical foods" shall mean prescription amino acid-based elemental formulas obtained through a pharmacy: *Provided*, that these foods are specifically designated and manufactured for the treatment of severe allergic conditions or short bowel. The provisions of this section shall not apply to persons with an intolerance for lactose or soy
Lyme Disease	§33-15-4p	Lyme Disease is to be covered by all health insurance policies. Coverage for Lyme Disease patients includes long-term antibiotic therapy when determined medically necessary by a licensed physician after evaluation. Insurers that provide insurance for an issue of accident of sickness on or after January 1, 2019, shall make benefits available to all on an expense-incurred basis. Individuals and groups or contracts that have security or protection against a loss or other financial burdens that are issued by nonprofit corporations shall provide coverage for long-term antibiotic therapy for Lyme Disease.
Insurance	§16-54-8	At a minimum, an insurance provider who offers an insurance product in this state, the Bureau for Medical Services, and the Public Employees Insurance Agency shall provide coverage for 20 visits per event of physical therapy, occupational therapy, osteopathic manipulation, a chronic pain management program, and chiropractic services, as defined in §30-16-3 of this code, when ordered by a health care practitioner to treat conditions that cause chronic pain. **Any deductible, coinsurance, or co-pay required for any of these services may not be greater than the deductible, coinsurance, or co-pay required for a primary care visit**

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Insurance Commissioner Rule	§33-16-3bb	The Insurance Commissioner: • shall propose rules in accordance with the provisions of §29A-3-1 et seq. of this code to develop a procedure for an expedited review of an adverse decision as set forth in this section. The Legislature finds that for the purposes of §20A-3-15 of this code, an emergency exists requiring the promulgation of an emergency rule to respond to the growing need in our state for substance abuse treatment. • shall develop a medical necessity review shall use an evidence-based and peer-reviewed clinical review tool. Rules shall ensure that the tool is based on appropriate evidence-based criteria that has been peer reviewed. The Insurance Commissioner shall propose rules for legislative approval in accordance with the provisions of §29A-3-1 et seq. of this code to develop the tool. • a group accident and sickness policy that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this state, or approved for issuance or renewal by the Insurance Commissioner, on or after January 1, 2019, shall provide benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities at the same level as other medical services offered by the group accident and sickness policy. • a health benefit plan offered by a health plan issuer that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this state, or approved for issuance or renewal by the Insurance Commissioner, on or after January 1, 2019, shall provide benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities at the same level as other medical services offered by the health benefit plan. • a health benefit plan offered by a health plan issuer that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this state, or approved for issuance or renewal by the Insurance Commissioner, on or after January 1, 2019, shall provide benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities at the same level as other medical services offered by the health benefit plan offered by a health plan issuer.
Conversion Privileges		
Right to Convert	§33-16A-1	A group policy or group subscriber contract which provides hospital, surgical or major medical expense insurance, or any combination of these, on an expense incurred basis, but not a policy which provides benefits for specific diseases or for accidental injuries only, shall provide that an employee or member whose insurance under the group policy or contract has been terminated for any reason, who has been continuously insured under the policy, or under any group policy providing similar benefits which it replaces, for at least three months immediately prior to termination, shall be entitled to have issued to him by the insurer a converted policy of health insurance. An employee or member is not entitled to this if termination occurred due to nonpayment, or the discontinued group coverage was replaced by similar group coverage within 31 days.
Standards for Converted Policies	§33-16A-3 §33-16A-4 §33-16A-8 §33-16A-2(b)	The following are standards for converted policies: 1. The converted policy must become effective upon termination of insurance coverage under the group policy. 2. The converted policy must cover the employee or member or his dependents, or both, who are covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent. 3. The converted policy may not contain exclusions for preexisting conditions, except to the extent that a condition was excluded from the group policy from which conversion was made. Benefits for pregnancy and childbirth may not be excluded from the converted policy if benefits for these conditions were provided under the group policy. 4. The converted policy must be offered without evidence of insurability.

Issuance of Converted Policy	§33-16A-2	Issuance of a converted policy shall be subject to the following conditions: 1. Written application for the converted policy shall be made and the first premium paid to the insurer not later than 31 days after termination. 2. The initial premium for the first 12 months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to individually underwritten standard risks, to the age and class of risk of each person to be covered under the converted policy and to the type and amount of insurance provided. The experience under converted policies shall not be an acceptable basis for establishing rates. If an insurer experiences or incurs losses for a period of two years on conversion policies which exceed earned premiums by more than 20%, the insurer may file with the commissioner amended renewal rates which will produce a loss ratio of not less than 120%. Conditions pertaining to health shall not be an acceptable basis for classification. The frequency of premium payment shall be the frequency customarily required by the insurer for the policy form and plan selected, provided that the insurer shall not require premium payments less frequently than quarterly.
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		Company approves the admission to the hospital (emergencies excepted).
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.
		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. 9. Premiums – COBRA allows employers to change 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.

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PPACA FILINGS		Please refer to documentation in SERFF's Online Help section for instructions on completing the required PPACA fields