West Virginia Office of the Insurance Commissioner
QHP REVIEW REQUIREMENTS CHECKLIST

GROUP MARKET

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
State Requirements ***All references are State of West Virignia statue and regulations, unless otherwise noted.*** ***Informational Letters (IL#), Insurance Bulletin (IB#), Insurance Rule (114), WV State Code (33, 30, 16), Public Health Service Act (PHSA)***		
General Requirements		
Fees	§33-6-34	The fee for a Form Filing is $100 per Filing, regardless of the number of forms.
Submission	§33-3-7 IL# 163	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 90 days prior to the start of Open Enrollment.
Readability and Size of Type	§33-29-5(a)(1) §33-16-4	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. Every printed portion of every such policy shall be plainly printed in type of which the face shall be not smaller than ten-point, and the exceptions shall be printed with the same prominence as the benefits to which they apply.
Compliance	§33-16 §114-10 §114-26 §114-28 §114-29	○ Group Accident and Sickness policy forms must comply with Chapter 16 of the WV Code. The Required provisions are found in §33-16-3. ○ Advertising – Department policy to require advertising filing on all Accident & Sickness products. ○ Rate Filing Accident and Sickness ○ Coordination of Benefit ○ Temporo/Craniomandibular Disorders
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.
Master Contract		Issuance of a master contract to the administrator of the group and individual certificates of insurance (outlines of coverage) to the members.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Legal Requirements		
Eligible Groups	§33-16-2	Group policies must come within any of the following classifications: ○ 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: • 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 • 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.
Network Adequacy	§114-100, §33-16-3gg, §33-24-7v, §33-25-8s, §33-25A-8v	The health carrier has filed their attestation and networks in accordant with Insurance Rule §114-100. You will be required to place a simple sentence on how to find a network provider in advertisements and all forms.
Surprise Billing	§33-2-24, IB# 22-01, IB# 22-02	The Insurance Commissioner shall enforce the applicable provisions of the No Surprises Act (H.R. 133, Public Law 116-260) against health insurers, medical providers, and health care facilities.
Policies discriminating among health care providers	§33-16-10, §33-24-43, §33-25-20, §33-25A-31	When any health insurance policy, health care services plan or other contract provides for the payment of medical expenses, benefits or procedures, such policy, plan or contract shall be construed to include payment to all health care providers including medical physicians, osteopathic physicians, podiatric physicians, chiropractic physicians, midwives and nurse practitioners who provide medical services, benefits or procedures which are within the scope of each respective provider's license. Any limitation or condition placed upon services, diagnoses or treatment by, or payment to any particular type of licensed provider shall apply equally to all types of licensed providers without unfair discrimination as to the usual and customary treatment procedures of any of the aforesaid providers.
Policies not to exclude insured's children from coverage; required services; coordination with other insurance	§33-16-11	An insurer issuing accident and sickness policies in this state shall provide coverage for the child or children of the insured without regard to the amount of child support ordered to be paid or actually paid by the insured, if any, and without regard to the fact that the insured may not have legal custody of the child or children or that the child or children may not be residing in the home of the insured.
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.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
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 Memebers	§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		
Autism Spectrum Disorders	§33-16-3v, §33-24-7k, §33-25A-8j, §33-25-8r	Must be in parity with other benefits.
Preventative Checkups	§33-16-3g, §33-16-3h, §33-16-3o, §33-16-3s, §33-24-7b, §33-24-7c, §33-24-7f, §33-24-7i §33-25-8a, §33-25-8b, §33-25-8e, §33-25-8g, §33-25A-8a, §33-25A-8b, §33-25A-8e, §33-25A-8h	Coverages and benefits for x-ray and laboratory services in connection with mammograms when medically appropriate and consistent with current guidelines from the United States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists; and a test for the human papilloma virus (HPV) when medically appropriate and consistent with current guidelines from either the United States Preventive Services Task Force or the American College of Obstetricians and Gynecologists, when performed for cancer screening or diagnostic services on a woman age 18 or over. For purposes of this article and section, "rehabilitation services" includes those services which are designed to remediate patient's condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status. Reimbursement or indemnification for colorectal cancer examinations and 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, 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 by the board of Medicine. The tests are as follows: An annual fecal occult blood test, a flexible sigmoidoscopy repeated every five years, a colonoscopy repeated every ten years and a double contrast barium enema repeated every five years. Annual screening for kidney disease as determined to be medically necessary by a physician using any combination of blood pressure testing, urine albumin or urine protein testing, and serum creatinine testing as recommended by the National Kidney Foundation.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Maternity & Post -Delivery Care	§33-16-3w, §33-16-3j, §33-24-7l, §33-25-8i §33-25A-8k	The health insurance for maternity services, shall provide coverage for maternity services for all persons participating in, or receiving coverage under the policy. To the extent that the provisions of this section require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits are not required of a health benefit plan when the plan is offered by a health care insurer in this state. Coverage required under this section may not be subject to exclusions or limitations which are not applied to other maternity coverage under the policy. 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; The plan must cover maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics or other established professional medical association; and The mother and her newborn child may be discharged prior to the expiration of the minimum length of stay required under this section only in those cases in which the decision to discharge is made by an attending provider in consultation with the mother.Benefits provided for under this section may be made subject to deductibles, coinsurance or other cost-sharing if such cost-sharing is no greater than cost-sharing for any preceding portion of the mother's or newborn child's hospital stay.Nothing in this section shall be construed to prevent a health insurer from negotiating with a provider the level and type of reimbursement for inpatient maternity or newborn care provided under a health benefit plan.
Treatment of Pain	§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.*

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Coverage for Amino-Based Formulas	§33-16-3bb, §33-24-7q, §33-25-8n, §33-25A-7q	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: ○ Immunoglobulin E and Non-immunoglobulin E-medicated allergies to multiple food proteins; ○ Severe food protein-induced enterocolitis syndrome; ○ Eosinophilic disorders as evidenced by the results of a biopsy; and ○ 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	§33-16-3zz, §33-25A-8p, §33-6-38	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 or 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.
Telehealth	§33-57-1	Health insurers, after July 1, 2020, to cover telehealth services if the same services are covered through face-to-face consultation by the policy, contract, or plan. A health insurer may not impose any annual or lifetime dollar maximum on coverage for telehealth services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy. Similarly, a health insurer may not impose upon a covered person any copayment, coinsurance or deductible amount for telehealth services that is not equally imposed upon all services covered under the policy, contract or plan.
Contraceptive Drugs	§33-16-3hh §33-24-7w, §33-25-8t, §33-25A-8w, §33-58-1	A health benefit plan that is issued on or after January 1, 2021, and provides for coverage for contraceptive drugs, must provide coverage for a 12-month refill of contraceptive drugs obtained at one time by the insured after the insured has completed the initial supply of the drugs, unless the insured request a smaller supply or the prescribing provider instructs that the insured must receive a smaller supply. The provision requiring coverage for 12-month refill for contraceptive drugs codified at §33-58-1 of this code is made applicable to the provisions of this article.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Diabetic Coverage	§33-59-1	Notwithstanding the provisions of §33-1-1 et seq. of this code, an insurer subject to §33-15-1 et seq., §33-16-1 et seq., §33-24-1 et seq., §33-25-1 et seq., and §33-25A-1 et seq. of this code which issues or renews a health insurance policy on or after July 1, 2020, shall provide coverage for prescription insulin drugs pursuant to this section. Cost sharing for a 30-day supply of a covered prescription insulin drug shall not exceed $100 for a 30-day supply of a covered prescription insulin, regardless of the quantity or type of prescription insulin used to fill the covered person's prescription needs. An insurer shall provide coverage for the following equipment and supplies for the treatment and/or management of diabetes for both insulin-dependent and noninsulin-dependent persons with diabetes and those with gestational diabetes: Blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar, and orthotics. An insurer shall 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. Diabetes self-management education shall be provided by a health care practitioner who has been appropriately trained.
Pharmacy Benefits	§33-51-11 IB# 21-07 IB# 22-04 §33-16-3q, §33-16-3x, §33-16-3y, §33-16-3z §33-24-7h, §33-24-7m, §33-24-7n, §33-24-7o §33-25-8f, §33-25-8j, §33-25-8k, §33-25-8l §33-25A-8g, §33-25A-8l, §33-25A-8m, §33-25A-8n	Please reference the Insurance Bulletins #21-07, #22-04 and WV Code §33-51-11 regarding Freedom of Consumer Choice for Pharmacy. Required use of mail-order pharmacy prohibited. Deductibles, copayments and coinsurance for anti-cancer medications. Any group accident and sickness insurance policy issued by an insurer pursuant to this article that covers anti-cancer medications that are injected or intravenously administered by a health care provider and patient administered anti-cancer medications, including, but not limited to, those medications orally administered or self-injected, may not require a less favorable basis for a copayment, deductible or coinsurance amount for patient administered anti-cancer medications than it requires for injected or intravenously administered anti-cancer medications, regardless of the formulation or benefit category determination by the policy or plan. Eye drop prescription refills. An insurance policy issued by an insurer pursuant to this article for prescription topical eye medication may not deny coverage for the refilling of a prescription for topical eye medication. Deductibles, copayments and coinsurance for abuse-deterrent opioid analgesic drugs.
Substance Use Disorder	§33-16-3cc, §33-24-7r, §33-25-8o, §33-25A-8r	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.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Expedited External Review of Adverse Health Determinations	§114-97-7	These are the procedures developed by the Insurance Commissioner to conducted an expedited review of any adverse health determinations.
Required Coverage for Dental Anesthesia Services	§33-16-3t, §33-24-7j, §33-25-8h, §33-25A-8i	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.
Assignment of certain benefits in dental care insurance coverage	§33-16-18, §33-24-45, §33-25-22, §33-25A-36	Any entity regulated under this article that provides dental care coverage to a covered person shall honor an assignment, made in writing by the person covered under the policy, of payments due under the policy to a dentist or a dental corporation for services provided to the covered person that are covered under the policy. Upon notice of the assignment, the entity shall make payments directly to the provider of the covered services. A dentist or dental corporation with a valid assignment may bill the entity and notify the entity of the assignment. Upon request of the entity, the dentist or dental corporation shall provide a copy of the assignment to the entity.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Prior Authorization	§33-16-3dd, §33-24-7s, §33-25-8p, §33-25A-8s IB# 21-08	Prior Authorization means obtaining advance approval from a health insurer about the coverage of a service or medication.
Mental Health Parity	§33-16-3ff. §33-24-7u, §33-25-8r, §33-25A-7u §114-64	An insurer or carrier is required to provide coverage for the prevention of, screening for, and treatment of behavioral health, mental health, and substance use disorders that is no less extensive that the medical/surgical benefits or coverage provided for any physical illness and that complies with the requirements of this rule and with W.Va. Code §§33-15-4u, 33-16-3ff, 33-24-7u, 33-25-8r, or 33-25A-8u, whichever is applicable.
Fairness in Cost-Sharing Calculation	§33-16-3ee, §33-24-7t, §33-25-8q, §33-25A-8t	Cost sharing means any copayment, coinsurance, or deductible required by or on behalf of an insured in order to receive a specific health care item or service covered by a health plan.
Step Therapy	§33-16-3aa, §33-24-7p, §33-25-8m, §33-25A-8o	Step therapy protocol means a protocol or program that establishes the specific sequence in which prescription drugs for a specificed medical condition, and medically appropriate for a particular patient, are covered by a health plan issuer or health benefit plan.
Emergency Services	§33-16-3i, §33-24-7e, §33-25-8d, §33-25A-8d	Every insurer shall provide coverage for emergency medical services, including prehospital services, to the extenet 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 emergncy services shall be based on the retrospective reivew of the presenting history and symptoms of the covered person.
Reconstruction surgery following mastectomies	§33-25A-8f, §33-24-7g, §33-16-3p	Any policy of insurance described in this article 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. All stages of reconstruction of the breast on which the mastectomy has been performed. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
Coordination of Benefits		
Coordination of Benefits	§33-16-14	Coordination of benefits with Medicaid.
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.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Rights of Renewability		
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.
Federal Requirements ***All references are Federal statue and regulations, unless otherwise noted.***		
Benefit Standards and Product Offerings		
Essential Health Benefits	45 CFR §156.110, §156.115, §156.120, §156.122 IL# 186A	○ Covers the Essential Health Benefit Package. • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance use disorder services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care. ○ Offers coverage that is substantially equal to the benchmark plan. ○ Demonstrates actuarial equivalence of substituted benefits if substituting benefits. ○ Provides required number of drugs per category and class. ○ 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.
Actuarial Value	45 CFR §156.135, §156.140	If health insurance, offers a plan that provides one of the following actuarial values (± 2%): ○ Bronze plan (AV 60%) ○ Silver plan (AV 70%) ○ Gold plan (AV 80%) ○ Platinum plan (AV 90%) ○ Catastrophic plan

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Catastrophic Plan	45 CFR §156.155	If offers a catastrophic plan, it is only offered to eligible individuals eligible to enroll in a catastrophic plan. Eligible individuals: ○ Individuals that have not attained the age of 30 before the beginning of the plan year ○ 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. ○ If offered, catastrophic plans are offered only in the individual exchange and not in the SHOP. ○ If offered, catastrophic plan complies with specific requirements for benefits.
Non-Discrimination	45 CFR §16.125, §156.225(b), §156.200(e)	○Does not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs. ○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. Complies with the Mental Health Parity and Addiction Equity Act.
Meaningul Difference		Standard does NOT apply to stand-alone dental plans. 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.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Rating		
Rating Factors	45 CFR §147.102, §156.255	Varies rates only based on: ○ Geographic area ○ Age (3 to 1) ○ Tobacco use (1.5 to 1) ○ Family composition: • Individual • Two-adult families • One-adult family with child(ren) • 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)	Sets rates for an entire benefit year, or for the SHOP, plan year.
Other Rating Provisions	45 CFR §156.255(b)	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)	Submits rate information to the Exchange at least annually.
Rate Increases	45 CFR §155.1020, §156.210(c), §154.215	Submits to the Exchange a justification for a rate increase prior to the implementation of the increase. Submits Rate Filing Justification, including: ○ 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) ○ Part III and the Redacted Actuarial Memorandum for public posting
Rate Increase Posting	45 CFR §155.1020, §156.210(c)	Prominently posts the rate increase justification on issuer Web site prior to the implementation of the increase.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Accreditation Standards		
Accreditation	45 CFR §156.275(a)(1)	Standard does NOT apply to stand-alone dental plans. ○ Accredited on the basis of local performance in the following categories by an accrediting entity recognized by CMS: ○ Clinical quality measures, such as the HEDIS ○ Patient experience ratings on a standardized CAHPS survey ○ Consumer access ○ Utilization management ○ Quality assurance ○ Provider credentialing ○ Complaints and appeals ○ Network adequacy and access ○ Patient information programs
Accreditation Survey Results	45 CFR §156.275(a)(2)	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, §156.275(b)	○ Accredited within the timeframe established by the Exchange. ○ 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.
Network Adequacy and Provider Directory		
General	45 CFR §156.230	Has a network for each plan with sufficient number and types of providers to ensure that all services are accessible without unreasonable delay.
Essential Community Providers	45 CFR §156.230(a)(1), §156.235	○ 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. ○ Issuer achieves at least 30% 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 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	○ 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.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Provider Directory	45 CFR §156.230(b)	○ Makes its provider directory available: • To the Exchange for publication online in accordance with guidance from the Exchange. • To potential enrollees in hard copy upon request. ○ 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)	○ Complies with all WV marketing laws & regulations. ○ Certificate of Readability provided WV Legislative Rules Title 114 Series 10; WV 33-29-5
Non-Discrimination	45 CFR §156.225(b)	Marketing practices do not discourage the enrollment of individuals with significant health needs.
Readability/Accessibility	45 CFR §155.230(b)	Provides applications and notices to applicants and enrollees all applications and other material: ○ In plain language ○ In a manner that is accessible and timely to: • Individuals living with disabilities • 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), 1311(g)	Attests to comply with future Federal rulemaking related to 45 CFR §156.200(b)(5).
Issuers will be required to attest to the Federal requirements included in the following sections.		
Transparency Requirements		
Coverage Transparency	45 CFR §155.1040, §156.220	Makes available to the public, Exchange, CMS, and the WV Insurance Commissioner in an accurate and timely manner, and in plain language: ○ Claims payment policies and practices ○ Periodic financial disclosures ○ Data on enrollment ○ Data on disenrollment ○ Data on the number of claims that are denied ○ Data on rating practices ○ Information on cost-sharing and payments for out-of network coverage ○ Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights)

GROUP MARKET

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Enrollee Cost-Sharing	45 CFR § 156.220(d)	○ 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. ○ Makes available such information through: • Internet website • Other means for individuals without access to the Internet
Appeals Notices	45 CFR §147.136(e)	Provides required notices on internal and external appeals in a culturally and linguistically appropriate manner.
Enrollment Periods		
Annual	45 CFR §155.410(b)	Provides an initial open enrollment period.
Special	45 CFR §155.420	○ Provides special enrollment periods for qualified enrollees. ○ Provides notice to individuals eligible to enroll during a special enrollment period.
Special Small Group Enrollment	45 CFR §147.104	The small group Special Enrollment Period takes place annually from **November 15 to December 15**, and it's only for coverage that kicks in on January 1. For that one month each year, the participation and contribution minimums that usually apply can't be enforced.
SHOP		
Specific Requirements	45 CFR §156.285	○ Accepts payment from the SHOP on behalf of a qualified employer or employee. ○ Adheres to the SHOP timeline for rate setting. ○ Charges the same contact rate for a plan year. ○ Adheres to the SHOP enrollment timeline and process. ○ Receives enrollment information electronically. ○ Provides new enrollees with an enrollment information package. ○ Reconciles enrollment files with the SHOP at least monthly. ○ Acknowledges receipt of enrollment information in accordance with SHOP standards. ○ Enrolls all qualified employees consistent with the employer's plan year. ○ Enrolls a qualified employee in accordance with the qualified employer's annual open enrollment period. ○ Provides special enrollment periods. ○ Provides an enrollment period for an employee who becomes a qualified employee outside of the initial or annual open enrollment period. ○ Adheres to effective dates of coverage. ○ Complies with requirements with respect to termination of employees. ○ 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	If elects not to seek recertification with the FFE: ○ Notifies the FFE of its decision prior to the beginning of the recertification process and procedures adopted by the FFE. ○ Fulfills its obligation to cover benefits for each enrollee through the end of the plan or benefit year. ○ Fulfills data reporting obligations from the last plan or benefit year of the certification. ○ Provides written notice to enrollees. ○ Terminates coverage for enrollees in the QHP.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Decertification	45 CFR §156.290	If decertified by the FFE, terminates coverage for enrollees only after: ○ The FFE has made notification ○ Enrollees have an opportunity to enroll in other coverage
Other Substantive and Reporting Requirements		
General Compliance	45 CFR §156.200(b)(2)	Complies with all Exchange processes, procedures, requirements.
User Fee	45 CFR §156.200(b)(6)	Pays the Exchange user fee.
Risk Adjustment	45 CFR §156.200(b)(7)	Complies with risk adjustment program.
Consumer Interest	45 CFR §155.1000(c)(2)	Is in the interest of qualified individuals.
Claims, Appeals, and External Review	45 CFR §147.136	Complies with internal claims and appeals and external review process.
Direct Primary Medical Home	45 CFR §156.245	If provides coverage through a direct primary care medical home: ○ Medical home meets criteria established by CMS ○ Issuer meets all requirements otherwise required ○ Issuer coordinates the services covered by the direct primary care medical home
Data-Sharing		○ Collects and transmits data to and from Exchanges, CMS, Treasury, and reinsurance entities. ○ 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	Reports to U.S. DCMS on prescription drug distribution and cost the following information (paid by PBM or issuer): ○ Percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies. ○ Percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type: • Independent pharmacy • Supermarket pharmacy • Mass merchandiser pharmacy ○ Aggregate amount and type of rebates, discounts, or price concessions that the issuer or its contracted PBM negotiates that are: • Attributable to patient utilization • Passed through to the issuer ○ Total number of prescriptions that were dispensed. ○ 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.