West Virginia Office of the Insurance Commissioner
QHP REVIEW REQUIREMENTS CHECKLIST

INDIVIDUAL MARKET

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
State Requirements ***All references are State of West Virginia statue and regulations, unless otherwise noted.*** ***Informational Letters (IL#), Insurance Bulletin (IB#), Insurance Rule (114), WV State Code (33, 30, 16, 5), 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 filed.
Submission	§33-3-7 IL# 163	All filings must be submitted through SERFF. Filing fees must be remitted via EFT 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.
Compliance	§114-10 §114-26 §114-28 §114-29	○ Advertising – Department policy to require advertising filing on all Accident & Sickness products. ○ Rate Filing Accident and Sickness ○ Coordination of Benefit ○ Temporo/Craniomandibular Disorders
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.
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.
Required Disclosure Provisions		
Insuring Clause	§33-6-11	On the First Page 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.
Free Look Provision (Right of Return)	§114-12-6.6.8	On the First Page of all policies, there must be a prominently displayed notice, stating that the policyholder has the right to return the policy within 10 days of its delivery and to have the premium refunded if after examination of the policy the policyholder is not satisfied for any reason.

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Definition of Special Terms	§114-12-6.6.4	A policy which provides for the payment of benefits based on standards described as usual and customary, reasonable and 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 Summary of Benefit Coverage (SBC) 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	(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 (preferably each page). (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.
Network Adequacy	§114-100 §33-15-4v	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	§33-15-14,	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	§33-15-16	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.

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Required Policy Provisions		
Entire Contract	§33-15-4(a)	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.
Time Limit on Certain Defenses	§33-15-4(b)	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.
Grace Period	§33-15-4(c)	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. For policyholders receiving APTC, the grace period must be 90 days after the initial premium is paid.
Reinstatement	§33-15-4(d)	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.
Notice of Claim	§33-15-4(e)	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.
Claim Forms	§33-15-4(f)	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.
Proof of Loss	§33-15-4(g)	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.
Payment of Claims	§33-15-4(l)	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.
Physical Exams & Autopsy	§33-15-4(j)	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.

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Legal Actions	§33-15-4(k)	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.
Non-Discrimination Among Health Care Providers	§33-15-14	Notwithstanding any other provisions of law, 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, physician assistants 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.

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Mandatory Benefits		
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 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.

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Assignment of certain benefits in dental care insurance coverage	§33-15-22, §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.
Preventative Checkups	§33-15-4c, §33-15-4f, §33-15-4h, §33-15-4i	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.
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.*

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Coverage for Amino-Based Formulas	§33-15-4q	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-mediated 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	§33-15-4p	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 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	§33-15-4w, §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.

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Diabetic Coverage	§33-59-1	The coverage must be in place with respect to an insurance policy, plan or contract that is issued or renewed on or after July 1, 2020. The bill mandates health insurers to cover at least one type of insulin in certain categories. The cost sharing payment, which is the total amount a covered person is required to pay at the point of sale in order to receive a prescription drug, for a 30-day supply of a covered prescription insulin drug may not exceed $100 irrespective of the quantity or type of prescription insulin used to fill the covered person's prescription needs. The legislation further requires health insurers to provide coverage for the following diabetes-related equipment and supplies: blood glucose monitors, monitor supplies, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar, and orthotics. Coverage must also be provided for diabetes self-management education to ensure that persons are aware of proper self-management and treatment of their diabetes, including information on proper diets.
Pharmacy Benefits	§33-51-11(a), §33-15-4(l), §33-15-4(n) IB# 21-07 and 22-04	Please reference the Insurance Bulletins and WV Code regarding Freedom of Consumer Choice for Pharmacy and PBM pharmacy networks.
Substance Use Disorder	§33-15-4(r)	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.
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.
Maternity and Post Delivery Care	§33-15-4(e), §33-15-4(k)	For plans that include maternity benefits: coverage for inpatient care in a duly licensed healthcare facility for a mother and her newly born infant for the length of time which the attending physician considers medically necessary for the mother or her newly born child. No plan may deny payment for a mother or her newborn child prior to 48 hours following a vaginal delivery or prior to 96 hours following a caesarean section delivery if the attending physician considers discharge medically inappropriate. For plans which provide coverages for post-delivery care to a mother and her newly born child in the home: coverage for inpatient care following childbirth as provided in §5-16-7(a)(4) of this code if inpatient care is determined to be medically necessary by the attending physician. These plans may include, among other things, medicines, medical equipment, prosthetic appliances, and any other inpatient and outpatient services and expenses considered appropriate and desirable by the agency.
Prior Authorization	§33-15-4(s)	Prior Authorization means obtaining advance approval from a health insurer about the coverage of a service or medication.
Mental Health Parity	§33-15-4(u)	The 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 than the coverage and reimbursement for the annual physical examination.
Fairness in Cost-Sharing Calculation	§33-15-4(t)	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.

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Step Therapy	§33-15-14(o)	Step therapy protocol means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition, and medically appropriate for a particular patient, are covered by a health plan issuer or health benefit plan.
Emergency Services	§33-15-21	Every insurer shall provide coverage for emergency medical services, including prehospital 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.
Reconstruction surgery following mastectomies	§33-15-4g	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.
Optional Policy Provisions Individual Accident and Sickness Policies		
Misstatement of Age	§33-15-5(b)	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)	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)	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)	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)	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.

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Conformity with State Statutes	§33-15-5(h)	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.
Illegal Occupation	§33-15-5(l)	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.
Intoxicants and Narcotics	§33-15-5(j)	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.
Common Exclusions or Restrictions		
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.
Replacement of Health Insurance		
The Application	§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.
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.

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Federal Requirements ***All references are Federal statue and regulations, unless otherwise noted.***		
Licensure, Solvency, and Standing		
Licensure and Solvency	45 CFR §156.200(b)(4)	○ Is licensed or authorized in WV to offer health insurance; or ○ 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		Is in good standing (no outstanding sanctions imposed by the OIC).
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.

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Cost-Sharing Requirements	45 CFR §156.130, §156.150 (for SADPs)	○ Complies with annual limitation on cost-sharing. ○ 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. ○ Complies with requirements related to coverage of out-of-network emergency services. FOR SHOP ONLY: ○ Complies with annual limitations on deductibles for employer-sponsored plans. FOR STAND-ALONE DENTAL ONLY: ○ Cost-sharing is “reasonable” for coverage of the pediatric dental EHB.
Actuarial Value	45 CFR §156.135 §156.140, §156.150 (for SADPs)	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
Catastrophic Plans	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 §156.125, §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.
Mental Health Parity and Addiction Equity Act	45 CFR §156.115	Complies with the Mental Health Parity and Addiction Equity Act.
Meaningful Difference		Standard does NOT apply to stand-alone dental plans.

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 justifications and 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.
Display of Stand-Alone Dental Plan Rates		FOR STAND-ALONE DENTAL ONLY: ○ Provides rates and indicates whether they are committing to rates reported or if they are reserving the option to charge additional premium amounts.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Accreditation Standards		
Accreditation	45 CFR §156.275(a)(1)	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 Standard does NOT apply to stand-alone dental plans.
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	○ Complies with WV network adequacy laws and regulations in addition to the specific requirements listed below. ○ Has a network for each plan with sufficient number and types of providers to ensure that all services are accessible without unreasonable delay. ○ 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. WV Informational Letter No. 112 provides standards related to distance/time and provider to enrollee ratios.
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

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
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.
Service Area	45 CFR §155.1055	Has a minimum service area of an entire county.
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). 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.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Segregation of Funds for Abortion Services		
Abortion Services	45 CFR §156.280 ACA §1303	○ Does not use federal funds for abortion. ○ Complies with procedures to ensure Federal funds are not misused, depositing payments into separate allocation accounts. ○ Submits segregation plan. ○ Provides annual assurance statement. ○ 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. ○ 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.
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)
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(e)	Provides an annual open enrollment period October 15 to December 7.
Special	45 CFR §155.420	○ Provides special enrollment periods for qualified enrollees. ○ Provides notice to individuals eligible to enroll during a special enrollment period.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Enrollment Process for Qualified Individuals		
Enrollment	45 CFR §156.265(b)(1), §156.265(b)(2), §156.265(c), §156.265(d), §156.265(e), §156.265(f), §156.400(d), §156.265(g)	○ Enrolls a qualified individual when Exchange notifies the issuer that the individual is a qualified individual and transmits information to the issuer. ○ If an applicant initiates enrollment directly with the issuer for enrollment through the Exchange, the issuer either: • Directs the individual to file an application with the Exchange; or, • Ensures that the individual received an eligibility determination for coverage through the Exchange via the Exchange Internet website ○ Accepts enrollment information consistent with the privacy and security requirements established by the Exchange. ○ Uses the premium payment process established by the Exchange. ○ Provides new enrollees an enrollment information package that is compliant with accessibility and readability standards. ○ Reconciles enrollment files with CMS and the Exchange no less than once a month. ○ Acknowledges receipt of enrollment information transmitted from the Exchange in accordance with Exchange standards.
Termination of Coverage of Qualified Individuals		
Termination Allowances	45 CFR §155.430(b), §156.270	Terminates coverage only if: ○ Enrollee is no longer eligible for coverage through the Exchange. ○ Enrollee's coverage is rescinded. ○ QHP terminates or is decertified. ○ Enrollee switches coverage: • During an annual open enrollment period • Special enrollment period ○ Obtains other minimum essential coverage. ○ For non-payment of premium only if: • Applies termination policy for non-payment of premium uniformly to enrollees in similar circumstances • Enrollee is delinquent on premium payment • Provides the enrollee with notice of such payment delinquency • 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), §156.270(b)	Provides reasonable notice of termination of coverage to the Exchange and enrollee (this includes the effective date of termination).
Records	45 CFR §155.430(c), §156.270(h)	Maintains records of terminations of coverage for auditing.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
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.
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.
Non-Discrimination	45 CFR §156.200(e)	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)	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.