WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

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OFFICE OF WEST VIRGINIA SECRETARY OF STATE

NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

RULE TYPE: Legislative ; CITE AUTHORITY W.Va. Code § 33-2-10

AMENDMENT TO AN EXISTING RULE: YES____ NO____

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

_____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: Series 55

TITLE OF RULE BEING PROPOSED: Guaranteed Issue of Individual Accident and Sickness Insurance

IN LIEU OF A PUBLIC HEARING, A COMMENT PERIOD HAS BEEN ESTABLISHED DURING WHICH ANY INTERESTED PERSON MAY SEND COMMENTS CONCERNING THESE PROPOSED RULES. THIS COMMENT PERIOD WILL END ON July 28, 1997 AT 9:00 a.m.

ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS.

Donna Quesenberry, Associate Counsel
ATTN: Legal Division
Offices of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

THE ISSUES TO BE HEARD SHALL BE LIMITED TO THIS PROPOSED RULE.

B. Keith Haught, General Counsel
Authorized Signature

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

$6.00

STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner
Legal Division

CECIL UNDERWOOD
Governor

HANLEY C. CLARK
Insurance Commissioner

June 27, 1997

HAND DELIVERED

Ms. Judy Cooper, Director
Administrative Law Division
Office of Secretary of State
State Capitol
Charleston, WV 25305

Dear Ms. Cooper:

Enclosed please find for filing one copy of the following:

(1) Notice of A Comment Period on a Proposed Rule;

(2) Consent of Tax and Revenue Cabinet Secretary to Proposed Rule;

(3) Brief Summary of Rule;

(4) Statement of Circumstances;

(5) Fiscal Note;

(6) The proposed rule entitled "Guaranteed Issue of Individual Accident and Sickness Insurance" (Series 55).

Please contact me if further information is required.

Sincerely,

Donna S. Quesenberry
Associate Counsel

DSQ/ksb

Enclosures

P.O. Box 50540
Charleston, West Virginia 25305-0540

"We are an Equal Opportunity Employer"

Telephone (304) 558-0401
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STATE OF WEST VIRGINIA
DEPARTMENT OF TAX AND REVENUE

CECIL H. UNDERWOOD
GOVERNOR

Charleston, West Virginia
P. O. Box 963
Charleston, WV 25324-0963
Ph. (304) 558-0211 - Fax (304) 558-2324

ROBIN C. CAPEHART
SECRETARY

CONSENT TO PROPOSAL OF RULE

To Whom It May Concern:

Pursuant to West Virginia Code §5F-2-2(a)(12), the undersigned hereby grants consent to the proposal of the following rule proposed by the Insurance Commissioner of the State of West Virginia: Title 114, Series 55, relating to "Guarantee Issue of Individual Accident and Sickness Insurance."

Dated this 26th day of June, 1997.

Robin Capehart
Secretary of Tax and Revenue

Insurance Commissioner
Legislative Rule
Title 114, Series 55

Guaranteed Issue of Individual Accident and Sickness Insurance

Title 114, Series 55

BRIEF SUMMARY OF RULE

This proposed rule implements the provisions of the House Bill 2667, effective April 12, 1997, which codified the federal mandates imposed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), commonly known as the Kennedy-Kassebaum bill, and related federal regulations. The rule sets forth guidelines for insurers required to provide accident and sickness insurance coverage to eligible individuals without the imposition of preexisting condition exclusions, the process by which insurers may elect to limit coverage, as well as the process for providing certification and disclosure of coverage, and the manner in which dependent coverage is to be treated under the statute.

Insurance Commissioner
Legislative Rule
Title 114, Series 55

Guaranteed Issue of Individual Accident and Sickness Insurance

Title 114, Series 55

STATEMENT OF CIRCUMSTANCES

On April 12, 1997, the West Virginia Legislature passed House Bill 2667 which codified the federal mandates imposed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), commonly known as the Kennedy-Kassebaum bill. The purpose of the proposed rule is to set forth the guidelines for insurers required to provide accident and sickness insurance coverage to eligible individuals without the imposition of preexisting condition exclusions, the process by which insurers may elect to limit coverage, as well as the process for providing certification and disclosure of coverage, and the manner in which dependent coverage is to be treated under the statute.

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Guaranteed Issue of Individual Accident and Sickness Insurance (Series 55)

Type of Rule: XX Legislative ____Interpretive ____Procedural

Agency: Insurance Commissioner

Address: Post Office Box 50540
2019 Washington Street, East
Charleston, West Virginia 25305-0540

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1. Effect of Proposed Rule

	ANNUAL		FISCAL YEAR		
	Increase	Decrease	Current	Next	Thereafter
ESTIMATED TOTAL COST	None				
PERSONAL SERVICES	None				
CURRENT EXPENSE	None				
REPAIRS AND ALTERNATIONS	None				
EQUIPMENT	None				
OTHER	None				

2. Explanation of above estimates:

This rule will have no additional fiscal impact upon state, local or federal government.

Rule Title: Guaranteed Issue of Individual Accident and Sickness Insurance (Series 55)

3. Objectives of these rules:

The objective of this proposed rule is to set forth the guidelines for insurers required to provide accident and sickness insurance coverage to eligible individuals without the imposition of preexisting condition exclusions, the process by which insurers may elect to limit coverage, as well as the process for providing certification and disclosure of coverage, and the manner in which dependent coverage is to be treated under the statute.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

None.

C. Economic Impact on Citizens/Public at Large.

None.

Date: 6/27/97

Signature of Agency Head or Authorized Representative

B. Keith Hoffman, General Counsel

114CSR55
WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 55
GUARANTEED ISSUE OF INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE

§114-55-1. General.

§114-55-2. Definitions.

§114-55-3. Election of Coverage.

§114-55-4. Dependent Coverage.

§114-55-5. Certification of Creditable Coverage.

§114-55-6. Determination of an Eligible Individual.

FILED

JUN 27 3 09 PM '97

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

114CSR55

WEST VIRGINIA LEGISLATIVE RULE

INSURANCE COMMISSIONER

SERIES 55

GUARANTEED ISSUE OF INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE

§114-55-1. General.

1.1. Scope. -- The purpose of this rule is to set forth guidelines for insurers required to provide accident and sickness insurance coverage to eligible individuals without the imposition of preexisting conditions exclusions, the election of coverage by insurers, certification and disclosure of coverage, and dependent coverage in accordance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related federal mandates. The requirements set forth in this rule apply to accident and sickness insurance coverage, other than excepted benefits, offered, sold, issued, renewed or in effect in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs.

1.2. Authority. -- W. Va. Code § 33-2-10.

1.3. Filing Date. --

1.4. Effective Date. --

§114-55-2. Definitions.

2.1. "Affiliation period" means a period of time that must expire before accident and sickness insurance coverage provided by a health maintenance organization becomes effective, and during which the health maintenance organization is not required to provide benefits.

2.2. "COBRA continuation provision" means any of the following:

a. Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines;

b. Part 6 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, other than Section 609 of such act; or

c. Title XXII of the Public Health Service Act.

2.3. "Commissioner" means the commissioner of insurance.

2.4. "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

a. A group health plan;

b. Accident and sickness insurance coverage;

c. Part A or part B of Title XVIII of the Social Security Act;

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

e. Chapter 55 of Title 10 of the United States Code;

f. A medical care program of the Indian Health Service or of a tribal organization;

g. A health plan offered under Chapter 89 of Title 5 of the United States Code;

h. A public health plan (as defined in federal regulations); or

i. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

j. The term "creditable coverage" does not include excepted benefits.

2.5. "Eligible individual" means an individual:

a. For whom, as of the date on which the individual seeks coverage, the aggregate period of creditable coverage is eighteen months or more and whose most recent prior creditable coverage was under a group health plan, governmental plan (as defined in section 3(32) of the Employee Retirement Income Security Act of 1974), church plan (as defined in section 3(33) of the Employee Retirement Income Security Act of 1974), or accident and sickness insurance coverage offered in connection with any such plan;

b. Who is not eligible for coverage under a group health plan, part A or part B of Title XVIII of the Social Security Act, or state plan under Title XIX of such act (or any

successor program), and does not have other accident and sickness insurance coverage;

c. With respect to whom the most recent prior creditable coverage was not terminated as a result of fraud, intentional misrepresentation of material fact under the terms of the coverage, or nonpayment of premium;

d. Who did not turn down an offer of continuation of coverage under a COBRA continuation provision or under a similar state program if it was offered; and

e. Who, if the individual elected such continuation coverage, has exhausted that coverage under the COBRA continuation provision or similar state program.

2.6. "Excepted benefits" means those benefits set forth in W. Va. Code § 33-15-2g.

2.7. "Individual market" means the market for accident and sickness insurance coverage offered to individuals other than in connection with a group health plan.

2.8. "Preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

2.9. "Significant break in coverage" means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

2.10. "Waiting period" means the period that must pass before an employee or dependent is eligible to enroll under the terms of a group health plan.

2.11. "Weighted average" means the average actuarial value of benefits provided by all the accident and sickness insurance coverage issued by one of the following:

a. An insurer in the individual market in the State during the previous calendar year, weighted by enrollment for each policy form, but not including coverage issued to eligible individuals; or

b. All insurers in the individual market in the State if the data are available for the previous calendar year, weighted by enrollment for each policy form.

§114-55-3. Election of Coverage.

3.1. Except as provided in subsection 3.2, an insurer that provides accident and sickness insurance coverage in the individual market may not decline to offer coverage or deny enrollment under any policy form it actively markets in the individual market to any eligible individual who requests coverage. An insurer is deemed to meet this requirement if, upon the request of an eligible individual, it promptly:

a. Provides information about all available coverage options;

b. Enrolls the individual in any coverage option the individual selects; and

c. Does not impose any preexisting condition exclusion on the individual.

3.2. An insurer may elect to limit the coverage required under subsection 3.1 if it offers eligible individuals at least two policy forms that meet the following requirements:

a. Each policy form must be designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals; and

b. The policy forms must be either the insurer's two most popular policy forms (as described in paragraph 1 of this subdivision and as set forth in W. Va. Code § 33-15-2b) or representative samples of individual accident and sickness insurance (as described in paragraph 2 of this subdivision and as set forth in W. Va. Code § 33-15-2b) offered by the insurer in this State.

1. The two most popular forms means the policy forms with the largest, and the second largest, premium volume for the last reporting year, for policies offered in the State. Premium volume means earned premiums for the last reporting year. The last reporting year is the period from October 1 through September 30 of the preceding year. Blocks of business closed under applicable State law are not included in calculating premium volume.

2. The two representative policy forms must meet the following requirements:

A. Include a lower-level coverage policy form under which the actuarial value of benefits under the coverage is at least 85 percent but not greater than 100 percent of the weighted average; and

B. Include a higher level coverage policy form under which the actuarial value of the benefits under the coverage is at least 15 percent greater than the actuarial value of the lower-level coverage policy form offered by an insurer in the State and at least 100 percent, but not greater than 120 percent of the weighted average;

C. Include benefits substantially similar to other individual accident and sickness insurance coverage offered by the insurer in the state;

D. Provide for risk adjustment, risk spreading, or a risk spreading mechanism, or otherwise provide some financial subsidization for eligible individuals; and

E. Meet all applicable State requirements.

3.3. All elections by insurers as provided for in subsection 3.2 of this rule must be applied uniformly to all eligible individuals in the State and must be effective for all policies offered during a period of at least two years.

3.4. Insurers making elections must do so on a form prescribed by the Commissioner within the following time frames:

a. For policy forms already being marketed as of July 1, 1997--no later than September 1, 1997.

b. For other policy forms--90 days before the beginning of the calendar year in which the insurer wants to market the policy form.

§114-55-4. Dependent Coverage.

4.1. If an eligible individual elects to enroll in individual accident and sickness insurance coverage that provides coverage for dependents, the insurer may apply a preexisting condition exclusion on any dependent who is not an eligible individual except as otherwise provided by this rule.

4.2. A child is deemed to be an eligible individual if the following conditions are met:

a. The child was covered under any creditable coverage within 30 days of birth, adoption, or placement for adoption; and

b. The child has not had a significant break in coverage.

4.3. An insurer in the individual market is not required to offer a family coverage option with any policy form.

§114-55-5. Certification of Creditable Coverage.

5.1. A certificate of creditable coverage must be provided, without charge, for individuals and dependents, who are or were covered under an individual accident and sickness insurance policy as follows:

a. An automatic certificate must be provided within a reasonable time period consistent with State law after the individual ceases to be covered under the policy.

b. A request for a certificate may be made by, or on behalf of, an individual within 24 months after coverage ends. After the request is received, an insurer must provide the certificate promptly. A certificate must be provided even if the individual has previously received an automatic certificate under subdivision a of this subsection.

c. An insurer must establish a procedure for individuals and dependents to request and receive certificates under subdivision b of this subsection.

5.2. Except as otherwise provided in this section, an insurer must provide a certificate of creditable coverage in writing. The requirements of this subsection are satisfied if the insurer provides the required information on a form certificate prescribed by the Commissioner.

a. A certificate of creditable coverage must include the following:

1. The date the certificate is issued;

2. The name of the individual or dependent for whom the certificate applies, and any other information necessary

for the insurer providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the policy and the name of the policyholder if the certificate is for, or includes, a dependent;

3. The name, address, and telephone number of the insurer required to provide the certificate;

4. The telephone number to call for further information regarding the certificate (if different from paragraph 3 of this subdivision);

5. Either one of the following:

A. A statement that the individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage;

B. Both the date the individual first sought coverage, as evidenced by a substantially complete application, and the date creditable coverage began; and

6. The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate.

b. No written certificate of creditable coverage must be provided if the following occurs:

1. An individual is entitled to receive a certificate;

2. The individual requests that the certificate be sent to another plan or insurer instead of to the individual;

3. The plan or insurer that would otherwise receive the certificate agrees to accept the required information through means other than a written certificate; and

4. The receiving plan or insurer receives the information from the sending insurer in the prescribed form within the time periods required in subsection 5.1 of this rule.

c. No certificate of creditable coverage is required to be furnished with respect to excepted benefits. If excepted benefits are provided concurrently with other creditable coverage

(so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to be disclosed under subsection 5.8 of this rule.

5.3. If an automatic certificate is provided under subdivision a of subsection 5.1 of this rule, the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate under subdivision b of subsection 5.1 of this rule, a certificate must be provided for each period of continuous coverage ending within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each period of continuous coverage.

5.4. The certificate of creditable coverage is required to be provided, without charge, to each individual described in subsection 5.1 of this rule or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail.

a. An insurer may provide a single certificate for both an individual and the individual's dependents if it provides all the required information for each individual and dependent, and separately states the information that is not identical.

b. If the certificate or certificates are provided to the individual and the individual's spouse at the individual's last known address, the requirements of this subsection are satisfied with respect to all individuals and dependents residing at that address.

c. If a dependent does not reside at the individual's last known address, a separate certificate must be provided to the dependent at the dependent's last known address.

d. If separate certificates are provided by mail to individuals and dependents who reside at the same address, separate mailings of each certificate are not required.

5.5. If an automatic certificate is required to be provided under subdivision a of subsection 5.1 of this rule, and the individual or dependent entitled to receive the certificate designates another individual or entity to receive the certificate, the insurer responsible for providing the certificate may provide the certificate to the designated party. If the certificate must be provided upon request under

subdivision b of subsection 5.1, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the insurer responsible for providing the certificate must provide the certificate to the designated party.

5.6. An insurer must use reasonable efforts to determine any information needed for a certificate relating to dependent coverage. If an automatic certificate must be furnished with respect to a dependent under subdivision a of subsection 5.1 of this rule, no individual certificate must be furnished until the insurer knows (or making reasonable efforts should know) of the dependent's cessation of coverage under the policy.

a. If a certificate furnished by an insurer does not provide the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in subdivision c of subsection 5.10 of this rule for demonstrating dependent status. An individual may, if necessary, use these procedures to demonstrate that a child was enrolled within 30 days of birth, adoption, or placement for adoption, in which case the child would not be subject to a preexisting condition exclusion under subsection 4.2 of this rule.

5.7. An insurer that cannot provide the names of dependents, or related coverage information, for purposes of providing a certificate of creditable coverage for a dependent may satisfy the requirements of paragraph 2 of subdivision a of subsection 5.2 of this rule by providing the name of the policyholder and specifying that the type of coverage provided in the certificate is for dependent coverage.

a. For purposes of certificates provided on the request of, or on behalf of, an individual under subdivision b of subsection 5.1 of this rule, an insurer must make reasonable efforts to obtain and provide the names of any dependent covered by the certificate if the information is requested. If an insurer responsible for providing a certificate does not provide the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in subdivision c of subsection 5.10 of this rule for submitting documentation to establish that the creditable coverage in the certificate applies to the dependent.

b. An insurer providing an automatic certificate that does not contain the name of a dependent must furnish a

certificate within 21 days after the individual ceases to be covered under the policy.

c. This subsection applies to certifications provided with respect to an event occurring before July 1, 1998.

d. This subsection applies to events described in subdivision a of subsection 5.6 of this rule that occur on or after October 1, 1996 but before June 1, 1997. An insurer offering individual accident and sickness insurance coverage is deemed to satisfy subsections 5.1 and 5.2 of this rule if a notice is provided in accordance with the provisions of this subsection.

5.8. If an individual enrolls in a group health plan and the plan or insurer uses the alternative method of determining creditable coverage described in 114CSR54, the individual provides a certificate of creditable coverage under subsection 5.1 or demonstrates creditable coverage subsection 5.9, and the plan or coverage in which the individual enrolls requests from the prior entity, the prior entity must:

a. Promptly identify for the requesting entity the categories of benefits and services used by the individual for which the requesting entity uses the alternative method of crediting coverage, and any specific information that the requesting entity requests to determine the individual's creditable coverage. The prior entity must promptly disclose to the requesting entity the creditable coverage information.

b. The prior entity furnishing the information under this subsection may charge the requesting entity for the reasonable cost of disclosing the information.

5.9. Individuals may establish creditable coverage (and waiting or affiliation periods) through means other than certificates. If the accuracy of a certificate is contested or a certificate is unavailable when needed by the individual, the individual has the right to demonstrate creditable coverage through the presentation of documents or other means. For example, the individual may make a demonstration if one of the following occurs:

a. An entity has failed to provide a certificate within the required time period;

b. The individual has creditable coverage but an entity may not be required to provide a certificate of the coverage;

c. The coverage is for a period before July 1, 1996;

d. The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or

e. The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

5.10. An insurer must take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether or not an individual has 18 months of creditable coverage. An insurer must treat the individual as having furnished a certificate if the individual attests to the period of creditable coverage, the individual presents relevant corroborating evidence of some creditable coverage during the period, and the individual cooperates with the insurer's efforts to verify the individual's coverage. For this purpose, cooperation includes providing, upon the insurer's request, a written authorization for the insurer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and dates of coverage. While an insurer may refuse to credit coverage if the individual fails to cooperate with the insurer's efforts to verify coverage, the insurer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

a. Documents that may establish creditable coverage (and waiting or affiliation periods) in the absence of a certificate include explanation of benefit claims or other correspondence from a plan or insurer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of creditable coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence period of health coverage.

b. Creditable coverage (and waiting period and affiliation period information) may be established through means

other than documentation, such as by a telephone call from the insurer to a third party verifying creditable coverage.

c. If in the course of providing evidence, including a certificate, of creditable coverage an individual is required to demonstrate dependent status, the insurer must treat the individual as having furnished a certificate showing the dependent status if the individual attests to the dependency and the period of the status and the individual cooperates with the insurer's efforts to verify the dependent status.

§114-55-6. Determination of an Eligible Individual.

6.1. Each insurer offering accident and sickness insurance coverage in the individual market is responsible for determining whether an applicant for coverage is an eligible individual and must exercise reasonable diligence in making this determination in a timely fashion.

a. If an insurer determines that an individual is an eligible individual, the insurer must promptly issue a policy to that individual.

b. If the information presented in or with an application is substantially insufficient for the insurer to make the determination described in subsection 6.1, the insurer may immediately request additional information from the individual, and must act promptly to make its determination after receipt of the requested information.

c. If an entity fails to provide a certificate of creditable coverage as required by this section, the insurer is subject to the procedures set forth in subsection 5.9 of this rule concerning the individual's right to demonstrate creditable coverage.