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WEST VIRGINIA LEGISLATURE

2020 REGULAR SESSION

Introduced

House Bill 4796

FISCAL NOTE

BY DELEGATES PUSHKIN, ROBINSON, ESTEP-BURTON,

WALKER, SKAFF AND BYRD

[Introduced February 11, 2020; Referred to the

Committee on Banking and Insurance then Finance]

1 A BILL to amend the Code of West Virginia, 1931, as amended by adding thereto a new section,
2 designated §5-16-7g; to amend said code by adding thereto a new section, designated
3 §33-15-4u; to amend said code by adding thereto a new section, designated §33-16-3ff;
4 to amend said code by adding thereto a new section, designated §33-24-7u, to amend
5 said code by adding thereto a new section, designated §33-25-8r; and to amend said code
6 by adding thereto a new section, designated §33-25A-8u, all relating to requiring the Public
7 Employees Agency and other health insurance providers to provide mental health parity
8 between behavioral health, mental health, substance use disorders and medical and
9 surgical procedures; providing definitions; providing mandatory coverage; providing for
10 mandatory annual reporting; providing for rulemaking; and setting forth an effective date.

Be it enacted by the Legislature of West Virginia:

CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE GOVERNOR, SECRETARY OF STATE AND ATTORNEY GENERAL; BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES, COMMISSIONS, OFFICES, PROGRAMS, ETC.

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

§5-16-7g. Mental health parity.

1 (a) As used in this section, the following words and phrases have the meaning given them
2 in this section unless the context clearly indicates otherwise:
3 "Behavioral, Mental Health and Substance Use Disorder" means a condition or disorder,
4 regardless of etiology, that may be the result of a combination of genetic and environmental
5 factors and that falls under any of the diagnostic categories listed in the mental disorders section
6 of the most recent version of:
7 (1) The International Statistical Classification of Diseases and Related Health Problems;

8 (2) The Diagnostic and Statistical Manual of Mental Disorders; or

9 (3) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy
10 and Early Childhood; and

11 Includes autism spectrum disorder.

12 (b) The Public Employees Insurance Agency is required to provide coverage for the
13 prevention of, screening for and treatment of behavioral, mental health and substance use
14 disorders that is no less extensive than the coverage provided for any physical illness and that
15 complies with the requirements of this section. This screening shall include, but is not limited to,
16 unhealthy alcohol use for adults, substance use for adults and adolescents, and depression
17 screening for adolescents and adults.

18 (c) The Public Employees Insurance Agency shall:

19 (1) Include coverage and reimbursement for behavioral health screenings using a
20 validated screening tool for behavioral health, which coverage and reimbursement is no less
21 extensive than the coverage and reimbursement for the annual physical examination.

22 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR
23 146.136(c)(4), or any successor regulation, regarding any limitations that are not expressed
24 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to
25 the limitations and examples listed in 45 CFR 146.136(c)(4)(ii) and (c)(4)(iii), or any successor
26 regulation and 78 FR 68246, include the methods by which the Public Employees Insurance
27 Agency establishes and maintains its provider network and responds to deficiencies in the ability
28 of its networks to provide timely access to care;

29 (3) Comply with the financial requirements and quantitative treatment limitations specified
30 in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation;

31 (4) Not apply any nonquantitative treatment limitations to benefits for behavioral, mental
32 health, and substance use disorders that are not applied to medical and surgical benefits within
33 the same classification of benefits;

34 (5) Establish procedures to authorize treatment with a nonparticipating provider if a
35 covered service is not available within established time and distance standards and within a
36 reasonable period after service is requested, and with the same coinsurance, deductible, or
37 copayment requirements as would apply if the service were provided at a participating provider,
38 and at no greater cost to the covered person than if the services were obtain at or form a
39 participating provider;
40 (6) If a covered person obtains a covered service from a nonparticipating provider because
41 the covered service is not available within the established time and distance standards, reimburse
42 treatment or services for behavioral, mental health, or substance use disorders required to be
43 covered pursuant to this subsection that are provided by a nonparticipating provider using the
44 same methodology that the Public Employees Insurance Agency uses to reimburse covered
45 medical services provided by nonparticipating providers and, upon request, provide evidence of
46 the methodology to the person or provider.
47 (d) If the Public Employees Insurance Agency offers a plan that does not cover services
48 provided by an out-of-network provider, it may provide the benefits required in subsection (c) if
49 the services are rendered by a provider who is designated by and affiliated with the Public
50 Employees Insurance Agency only if the same requirements apply for services for a physical
51 illness;
52 (e) In the event of a concurrent review for a claim for coverage of services for the
53 prevention of, screening for, and treatment of behavioral, mental health, and substance use
54 disorders, the service continues to be a covered service until the Public Employees Insurance
55 Agency notifies the covered person of the determination of the claim;
56 (f) Unless denied for nonpayment of premium, a denial of reimbursement for services for
57 the prevention of, screening for, or treatment of behavioral, mental health, and substance use
58 disorders by the Public Employees Insurance Agency must include the following language:
59 (1) A statement explaining that covered persons are protected under this section, which

60 provides that limitations placed on the access to mental health and substance use disorder
61 benefits may be no greater than any limitations placed on access to medical and surgical benefits;
62 (2) A statement providing information about the Consumer Services Division of the West
63 Virginia Office of the Insurance Commissioner if the covered person believes his or her rights
64 under this section have been violated; and
65 (3) A statement specifying that covered persons are entitled, upon request to the Public
66 Employees Insurance Agency, to a copy of the medical necessity criteria for any behavioral,
67 mental health, and substance use disorder benefit.
68 (g) On or after June 1, 2021 and annually thereafter, the Public Employees Insurance
69 Agency shall submit a written report to the Joint Committee on Government and Finance that
70 contains the following information regarding plans offered pursuant to this section:
71 (1) Data that demonstrates parity compliance for adverse determination regarding claims
72 for behavioral, mental health, or substance use disorder services and includes the total number
73 of adverse determinations for such claims;
74 (2) A description of the process used to develop and select:
75 (A) The medical necessity criteria used in determining benefits for behavioral health,
76 mental health, and substance use disorders; and
77 (B) The medical necessity criteria used in determining medical and surgical benefits;
78 (3) Identification of all nonquantitative treatment limitations that are applied to benefits for
79 behavioral, mental health, and substance use disorders and to medical and surgical benefits
80 within each classification of benefits; and
81 (4)The results of analyses demonstrating that, for medical necessity criteria descried in
82 subsection (g)(2) of this section and for each nonquantitative treatment limitation identified in
83 subsection (g)(3) of this section, as written and in operation, the processes, strategies, evidentiary
84 standards, or other factors used in applying the medical necessity criteria and each
85 nonquantitative treatment limitation to benefits for behavioral, mental health, and substance use

86 disorders within each classification of benefits are comparable to, and are applied no more
87 stringently than, the processes, strategies, evidentiary standards, or other factors used in applying
88 the medical necessity criteria and each nonquantitative treatment limitation to medical and
89 surgical benefits within the corresponding classification of benefits.
90 (5) The Public Employees Insurance Agency's report of the analyses regarding
91 nonquantitative treatment limitations shall include at a minimum:
92 (A) Identify factors used to determine whether a nonquantitative treatment limitation will
93 apply to a benefit, including factors that were considered but rejected;
94 (B) Identify and define the specific evidentiary standards used to define the factors and
95 any other evidence relied on in designing each nonquantitative treatment limitation;
96 (C) Provide the comparative analyses, including the results of the analyses, performed to
97 determine that the processes and strategies used to design each nonquantitative treatment
98 limitation, as written, and the written processes and strategies used to apply each nonquantitative
99 treatment limitation for benefits for behavioral, mental health, and substance use disorders are
100 comparable to, and are applied no more stringently than, the processes and strategies used to
101 design and apply each nonquantitative treatment limitation, as written, and the written processes
102 and strategies used to apply each nonquantitative treatment limitation for medical and surgical
103 benefits;
104 (D) Provide the comparative analysis, including the results of the analyses, performed to
105 determine that the processes and strategies used to apply each nonquantitative treatment
106 limitation, in operation, for benefits for behavioral, mental health, and substance use disorders
107 are comparable to, and are applied no more stringently than, the processes and strategies used
108 to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits;
109 and
110 (E) Disclose the specific findings and conclusions reached by the Public Employees
111 Insurance Agency that the results of the analyses indicate that each health benefit plan offered

112 by the Public Employees Insurance Agency complies with subsection (c) and this section.

113 (h) The Public Employees Insurance Agency shall adopt legislative rules to comply with

114 the provisions of this section. These rules or amendments to rules shall be proposed pursuant to

115 the provisions of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by

116 the Legislature during its regular session in the year 2021.

117 (i) This section is effective for policies, contracts, plans or agreements, beginning on or

118 after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject

119 to this article that are delivered, executed, issues, amended, adjusted, or renewed in this state on

120 or after the effective date of this section.

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4u. Mental health parity.

1 (a) As used in this section, the following words and phrases have the meaning given them

2 in this section unless the context clearly indicates otherwise:

3 “Behavioral, Mental Health and Substance Use Disorder” means a condition or disorder,

4 regardless of etiology, that may be the result of a combination of genetic and environmental

5 factors and that falls under any of the diagnostic categories listed in the mental disorders section

6 of the most recent version of:

7 (1) The International Statistical Classification of Diseases and Related Health Problems;

8 (2) The Diagnostic and Statistical Manual of Mental Disorders; or

9 (3) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy

10 and Early Childhood; and

11 Includes autism spectrum disorder.

12 (b) The Carrier is required to provide coverage for the prevention of, screening for and

13 treatment of behavioral, mental health and substance use disorders that is no less extensive than

14 the coverage provided for any physical illness and that complies with the requirements of this
15 section. This screening shall include, but is not limited to, unhealthy alcohol use for adults,
16 substance use for adults and adolescents, and depression screening for adolescents and adults.
17 (c) The Carrier shall:
18 (1) Include coverage and reimbursement for behavioral health screenings using a
19 validated screening tool for behavioral health, which coverage and reimbursement is no less
20 extensive than the coverage and reimbursement for the annual physical examination.
21 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR
22 146.136 (c)(4), or any successor regulation, regarding any limitations that are not expressed
23 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to
24 the limitations and examples listed in 45 CFR 146.136 (c)(4)(ii) and (c)(4)(iii), or any successor
25 regulation and 78 FR 68246, include the methods by which the Carrier establishes and maintains
26 its provider network and responds to deficiencies in the ability of its networks to provide timely
27 access to care;
28 (3) Comply with the financial requirements and quantitative treatment limitations specified
29 in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation;
30 (4) Not apply any nonquantitative treatment limitations to benefits for behavioral, mental
31 health, and substance use disorders that are not applied to medical and surgical benefits within
32 the same classification of benefits;
33 (5) Establish procedures to authorize treatment with a nonparticipating provider if a
34 covered service is not available within established time and distance standards and within a
35 reasonable period after service is requested, and with the same coinsurance, deductible, or
36 copayment requirements as would apply if the service were provided at a participating provider,
37 and at no greater cost to the covered person than if the services were obtain at or form a
38 participating provider;
39 (6) If a covered person obtains a covered service from a nonparticipating provider because

40 the covered service is not available within the established time and distance standards, reimburse
41 treatment or services for behavioral, mental health, or substance use disorders required to be
42 covered pursuant to this subsection that are provided by a nonparticipating provider using the
43 same methodology that the Carrier uses to reimburse covered medical services provided by
44 nonparticipating providers and, upon request, provide evidence of the methodology to the person
45 or provider.

46 (d) If the Carrier offers a plan that does not cover services provided by an out-of-network
47 provider, it may provide the benefits required in subsection (c) if the services are rendered by a
48 provider who is designated by and affiliated with the Carrier only if the same requirements apply
49 for services for a physical illness;

50 (e) In the event of a concurrent review for a claim for coverage of services for the
51 prevention of, screening for, and treatment of behavioral, mental health, and substance use
52 disorders, the service continues to be a covered service until the Carrier notifies the covered
53 person of the determination of the claim;

54 (f) Unless denied for nonpayment of premium, a denial of reimbursement for services for
55 the prevention of, screening for, or treatment of behavioral, mental health, and substance use
56 disorders by the Carrier must include the following language:

57 (1) A statement explaining that covered persons are protected under this section, which
58 provides that limitations placed on the access to mental health and substance use disorder
59 benefits may be no greater than any limitations placed on access to medical and surgical benefits;

60 (2) A statement providing information about the Consumer Services Division of the West
61 Virginia Office of the Insurance Commissioner if the covered person believes his or her rights
62 under this section have been violated; and

63 (3) A statement specifying that covered persons are entitled, upon request to the Carrier,
64 to a copy of the medical necessity criteria for any behavioral, mental health, and substance use
65 disorder benefit.

66 (g) On or after June 1, 2021, and annually thereafter, the Insurance Commissioner shall
67 submit a written report to the Joint Committee on Government and Finance that contains the
68 following information on plans which fall under this section regarding plans offered pursuant to
69 this section:
70 (1) Data that demonstrates parity compliance for adverse determination regarding claims
71 for behavioral, mental health, or substance use disorder services and includes the total number
72 of adverse determinations for such claims;
73 (2) A description of the process used to develop and select:
74 (A) The medical necessity criteria used in determining benefits for behavioral health,
75 mental health, and substance use disorders; and
76 (B) The medical necessity criteria used in determining medical and surgical benefits;
77 (3) Identification of all nonquantitative treatment limitations that are applied to benefits for
78 behavioral, mental health, and substance use disorders and to medical and surgical benefits
79 within each classification of benefits; and
80 (4)The results of analyses demonstrating that, for medical necessity criteria descried in
81 subsection (g)(2) of this section and for each nonquantitative treatment limitation identified in
82 subsection (g)(3) of this section, as written and in operation, the processes, strategies, evidentiary
83 standards, or other factors used in applying the medical necessity criteria and each
84 nonquantitative treatment limitation to benefits for behavioral, mental health, and substance use
85 disorders within each classification of benefits are comparable to, and are applied no more
86 stringently than, the processes, strategies, evidentiary standards, or other factors used in applying
87 the medical necessity criteria and each nonquantitative treatment limitation to medical and
88 surgical benefits within the corresponding classification of benefits.
89 (5) The Insurance Commissioner's report of the analyses regarding nonquantitative
90 treatment limitations shall include at a minimum:
91 (A) Identify factors used to determine whether a nonquantitative treatment limitation will

92 apply to a benefit, including factors that were considered but rejected;

93 (B) Identify and define the specific evidentiary standards used to define the factors and

94 any other evidence relied on in designing each nonquantitative treatment limitation;

95 (C) Provide the comparative analyses, including the results of the analyses, performed to

96 determine that the processes and strategies used to design each nonquantitative treatment

97 limitation, as written, and the written processes and strategies used to apply each nonquantitative

98 treatment limitation for benefits for behavioral, mental health, and substance use disorders are

99 comparable to, and are applied no more stringently than, the processes and strategies used to

100 design and apply each nonquantitative treatment limitation, as written, and the written processes

101 and strategies used to apply each nonquantitative treatment limitation for medical and surgical

102 benefits;

103 (D) Provide the comparative analysis, including the results of the analyses, performed to

104 determine that the processes and strategies used to apply each nonquantitative treatment

105 limitation, in operation, for benefits for behavioral, mental health, and substance use disorders

106 are comparable to, and are applied no more stringently than, the processes and strategies used

107 to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits;

108 and

109 (E) Disclose the specific findings and conclusions reached by the Insurance

110 Commissioner that the results of the analyses indicate that each health benefit plan offered under

111 the provisions of this section complies with section (c) and this section.

112 (h) The Insurance Commission shall adopt legislative rules to comply with the provisions

113 of this section. These rules or amendments to rules shall be proposed pursuant to the provisions

114 of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the Legislature

115 during its regular session in the year 2021.

116 (i) This section is effective for policies, contracts, plans or agreements, beginning on or

117 after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject

118 to this article that are delivered, executed, issues, amended, adjusted, or renewed in this state on
119 or after the effective date of this section.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3ff. Mental health parity.

1 (a) As used in this section, the following words and phrases have the meaning given them
2 in this section unless the context clearly indicates otherwise:
3 "Behavioral, Mental Health and Substance Use Disorder" means a condition or disorder,
4 regardless of etiology, that may be the result of a combination of genetic and environmental
5 factors and that falls under any of the diagnostic categories listed in the mental disorders section
6 of the most recent version of:
7 (1) The International Statistical Classification of Diseases and Related Health Problems;
8 (2) The Diagnostic and Statistical Manual of Mental Disorders; or
9 (3) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy
10 and Early Childhood; and
11 Includes autism spectrum disorder.
12 (b) The Carrier is required to provide coverage for the prevention of, screening for and
13 treatment of behavioral, mental health and substance use disorders that is no less extensive than
14 the coverage provided for any physical illness and that complies with the requirements of this
15 section. This screening shall include but is not limited to unhealthy alcohol use for adults,
16 substance use for adults and adolescents, and depression screening for adolescents and adults.
17 (c) The Carrier shall:
18 (1) Include coverage and reimbursement for behavioral health screenings using a
19 validated screening tool for behavioral health, which coverage and reimbursement is no less
20 extensive than the coverage and reimbursement for the annual physical examination.
21 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR
22 146.136 (c)(4), or any successor regulation, regarding any limitations that are not expressed

numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to the limitations and examples listed in 45 CFR 146.136 (c)(4)(ii) and (c)(4)(iii), or any successor regulation and 78 FR 68246, include the methods by which the Carrier establishes and maintains its provider network and responds to deficiencies in the ability of its networks to provide timely access to care;

(3) Comply with the financial requirements and quantitative treatment limitations specified in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation;

(4) Not apply any nonquantitative treatment limitations to benefits for behavioral, mental health, and substance use disorders that are not applied to medical and surgical benefits within the same classification of benefits;

(5) Establish procedures to authorize treatment with a nonparticipating provider if a covered service is not available within established time and distance standards and within a reasonable period after service is requested, and with the same coinsurance, deductible, or copayment requirements as would apply if the service were provided at a participating provider, and at no greater cost to the covered person than if the services were obtain at or form a participating provider;

(6) If a covered person obtains a covered service from a nonparticipating provider because the covered service is not available within the established time and distance standards, reimburse treatment or services for behavioral, mental health, or substance use disorders required to be covered pursuant to this subsection that are provided by a nonparticipating provider using the same methodology that the Carrier uses to reimburse covered medical services provided by nonparticipating providers and, upon request, provide evidence of the methodology to the person or provider.

(d) If the Carrier offers a plan that does not cover services provided by an out-of-network provider, it may provide the benefits required in subsection (c) if the services are rendered by a provider who is designated by and affiliated with the Carrier only if the same requirements apply

49 for services for a physical illness;

50 (e) In the event of a concurrent review for a claim for coverage of services for the
51 prevention of, screening for, and treatment of behavioral, mental health, and substance use
52 disorders, the service continues to be a covered service until the Carrier notifies the covered
53 person of the determination of the claim;

54 (f) Unless denied for nonpayment of premium, a denial of reimbursement for services for
55 the prevention of, screening for, or treatment of behavioral, mental health, and substance use
56 disorders by the Carrier must include the following language:

57 (1) A statement explaining that covered persons are protected under this section, which
58 provides that limitations placed on the access to mental health and substance use disorder
59 benefits may be no greater than any limitations placed on access to medical and surgical benefits;

60 (2) A statement providing information about the Consumer Services Division of the Office
61 of the West Virginia Insurance Commissioner if the covered person believes his or her rights
62 under this section have been violated; and

63 (3) A statement specifying that covered persons are entitled, upon request to the Carrier,
64 to a copy of the medical necessity criteria for any behavioral, mental health, and substance use
65 disorder benefit.

66 (g) On or after June 1, 2021, and annually thereafter, the Insurance Commissioner shall
67 submit a written report to the Joint Committee on Government and Finance that contains the
68 following information regarding plans offered pursuant to this section:

69 (1) Data that demonstrates parity compliance for adverse determination regarding claims
70 for behavioral, mental health, or substance use disorder services and includes the total number
71 of adverse determinations for such claims;

72 (2) A description of the process used to develop and select:

73 (A) The medical necessity criteria used in determining benefits for behavioral health,
74 mental health, and substance use disorders; and

75 (B) The medical necessity criteria used in determining medical and surgical benefits;

76 (3) Identification of all nonquantitative treatment limitations that are applied to benefits for
77 behavioral, mental health, and substance use disorders and to medical and surgical benefits
78 within each classification of benefits; and

79 (4)The results of analyses demonstrating that, for medical necessity criteria descried in
80 subsection (g)(2) of this section and for each nonquantitative treatment limitation identified in
81 subsection (g)(3) of this section, as written and in operation, the processes, strategies, evidentiary
82 standards, or other factors used in applying the medical necessity criteria and each
83 nonquantitative treatment limitation to benefits for behavioral, mental health, and substance use
84 disorders within each classification of benefits are comparable to, and are applied no more
85 stringently than, the processes, strategies, evidentiary standards, or other factors used in applying
86 the medical necessity criteria and each nonquantitative treatment limitation to medical and
87 surgical benefits within the corresponding classification of benefits.

88 (5) The Insurance Commissioner's report of the analyses regarding nonquantitative
89 treatment limitations shall include at a minimum:

90 (A) Identify factors used to determine whether a nonquantitative treatment limitation will
91 apply to a benefit, including factors that were considered but rejected;

92 (B) Identify and define the specific evidentiary standards used to define the factors and
93 any other evidence relied on in designing each nonquantitative treatment limitation;

94 (C) Provide the comparative analyses, including the results of the analyses, performed to
95 determine that the processes and strategies used to design each nonquantitative treatment
96 limitation, as written, and the written processes and strategies used to apply each nonquantitative
97 treatment limitation for benefits for behavioral, mental health, and substance use disorders are
98 comparable to, and are applied no more stringently than, the processes and strategies used to
99 design and apply each nonquantitative treatment limitation, as written, and the written processes
100 and strategies used to apply each nonquantitative treatment limitation for medical and surgical

101 benefits;

102 (D) Provide the comparative analysis, including the results of the analyses, performed to
103 determine that the processes and strategies used to apply each nonquantitative treatment
104 limitation, in operation, for benefits for behavioral, mental health, and substance use disorders
105 are comparable to, and are applied no more stringently than, the processes and strategies used
106 to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits;
107 and

108 (E) Disclose the specific findings and conclusions reached by the Insurance
109 Commissioner that the results of the analyses indicate that each health benefit plan which falls
110 under the provisions of this section complies with section (c) and this section.

111 (h) The Insurance Commission shall adopt legislative rules to comply with the provisions
112 of this section. These rules or amendments to rules shall be proposed pursuant to the provisions
113 of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the Legislature
114 during its regular session in the year 2021.

115 (i) This section is effective for policies, contracts, plans or agreements, beginning on or
116 after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject
117 to this article that are delivered, executed, issues, amended, adjusted, or renewed in this state on
118 or after the effective date of this section.

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS AND HEALTH SERVICE CORPORATIONS.

§33-24-7u. Mental Health Parity.

1 (a) As used in this section, the following words and phrases have the meaning given them
2 in this section unless the context clearly indicates otherwise:

3 “Behavioral, Mental Health and Substance Use Disorder” means a condition or disorder,

4 regardless of etiology, that may be the result of a combination of genetic and environmental
5 factors and that falls under any of the diagnostic categories listed in the mental disorders section
6 of the most recent version of:
7 (1) The International Statistical Classification of Diseases and Related Health Problems;
8 (2) The Diagnostic and Statistical Manual of Mental Disorders; or
9 (3) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy
10 and Early Childhood; and
11 Includes autism spectrum disorder.
12 (b) The Carrier is required to provide coverage for the prevention of, screening for and
13 treatment of behavioral, mental health and substance use disorders that is no less extensive than
14 the coverage provided for any physical illness and that complies with the requirements of this
15 section. This screening shall include, but is not limited to, unhealthy alcohol use for adults,
16 substance use for adults and adolescents, and depression screening for adolescents and adults.
17 (c) The Carrier shall:
18 (1) Include coverage and reimbursement for behavioral health screenings using a
19 validated screening tool for behavioral health, which coverage and reimbursement is no less
20 extensive than the coverage and reimbursement for the annual physical examination.
21 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR
22 146.136 (c)(4), or any successor regulation, regarding any limitations that are not expressed
23 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to
24 the limitations and examples listed in 45 CFR 146.136 (c)(4)(ii) and (c)(4)(iii), or any successor
25 regulation and 78 FR 68246, include the methods by which the Carrier establishes and maintains
26 its provider network and responds to deficiencies in the ability of its networks to provide timely
27 access to care;
28 (3) Comply with the financial requirements and quantitative treatment limitations specified
29 in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation;

30 (4) Not apply any nonquantitative treatment limitations to benefits for behavioral, mental
31 health, and substance use disorders that are not applied to medical and surgical benefits within
32 the same classification of benefits;
33 (5) Establish procedures to authorize treatment with a nonparticipating provider if a
34 covered service is not available within established time and distance standards and within a
35 reasonable period after service is requested, and with the same coinsurance, deductible, or
36 copayment requirements as would apply if the service were provided at a participating provider,
37 and at no greater cost to the covered person than if the services were obtain at or form a
38 participating provider;
39 (6) If a covered person obtains a covered service from a nonparticipating provider because
40 the covered service is not available within the established time and distance standards, reimburse
41 treatment or services for behavioral, mental health, or substance use disorders required to be
42 covered pursuant to this subsection that are provided by a nonparticipating provider using the
43 same methodology that the Carrier uses to reimburse covered medical services provided by
44 nonparticipating providers and, upon request, provide evidence of the methodology to the person
45 or provider.
46 (d) If the Carrier offers a plan that does not cover services provided by an out-of-network
47 provider, it may provide the benefits required in subsection (c) if the services are rendered by a
48 provider who is designated by and affiliated with the Carrier only if the same requirements apply
49 for services for a physical illness;
50 (e) In the event of a concurrent review for a claim for coverage of services for the
51 prevention of, screening for, and treatment of behavioral, mental health, and substance use
52 disorders, the service continues to be a covered service until the Carrier notifies the covered
53 person of the determination of the claim;
54 (f) Unless denied for nonpayment of premium, a denial of reimbursement for services for
55 the prevention of, screening for, or treatment of behavioral, mental health, and substance use

56 disorders by the Carrier must include the following language:

57 (1) A statement explaining that covered persons are protected under this section, which
58 provides that limitations placed on the access to mental health and substance use disorder
59 benefits may be no greater than any limitations placed on access to medical and surgical benefits;

60 (2) A statement providing information about the Consumer Services Division of the Office
61 of the West Virginia Insurance Commissioner if the covered person believes his or her rights
62 under this section have been violated; and

63 (3) A statement specifying that covered persons are entitled, upon request to the Carrier,
64 to a copy of the medical necessity criteria for any behavioral, mental health, and substance use
65 disorder benefit.

66 (g) On or after June 1, 2021, and annually thereafter, the Insurance Commissioner shall
67 submit a written report to the Joint Committee on Government and Finance that contains the
68 following information regarding plans offered pursuant to this section:

69 (1) Data that demonstrates parity compliance for adverse determination regarding claims
70 for behavioral, mental health, or substance use disorder services and includes the total number
71 of adverse determinations for such claims;

72 (2) A description of the process used to develop and select:

73 (A) The medical necessity criteria used in determining benefits for behavioral health,
74 mental health, and substance use disorders; and

75 (B) The medical necessity criteria used in determining medical and surgical benefits;

76 (3) Identification of all nonquantitative treatment limitations that are applied to benefits for
77 behavioral, mental health, and substance use disorders and to medical and surgical benefits
78 within each classification of benefits; and

79 (4)The results of analyses demonstrating that, for medical necessity criteria descried in
80 subsection (g)(2) of this section and for each nonquantitative treatment limitation identified in
81 subsection (g)(3) of this section, as written and in operation, the processes, strategies, evidentiary

82 standards, or other factors used in applying the medical necessity criteria and each
83 nonquantitative treatment limitation to benefits for behavioral, mental health, and substance use
84 disorders within each classification of benefits are comparable to, and are applied no more
85 stringently than, the processes, strategies, evidentiary standards, or other factors used in applying
86 the medical necessity criteria and each nonquantitative treatment limitation to medical and
87 surgical benefits within the corresponding classification of benefits.
88 (5) The Insurance Commissioner's report of the analyses regarding nonquantitative
89 treatment limitations shall include at a minimum:
90 (A) Identify factors used to determine whether a nonquantitative treatment limitation will
91 apply to a benefit, including factors that were considered but rejected;
92 (B) Identify and define the specific evidentiary standards used to define the factors and
93 any other evidence relied on in designing each nonquantitative treatment limitation;
94 (C) Provide the comparative analyses, including the results of the analyses, performed to
95 determine that the processes and strategies used to design each nonquantitative treatment
96 limitation, as written, and the written processes and strategies used to apply each nonquantitative
97 treatment limitation for benefits for behavioral, mental health, and substance use disorders are
98 comparable to, and are applied no more stringently than, the processes and strategies used to
99 design and apply each nonquantitative treatment limitation, as written, and the written processes
100 and strategies used to apply each nonquantitative treatment limitation for medical and surgical
101 benefits;
102 (D) Provide the comparative analysis, including the results of the analyses, performed to
103 determine that the processes and strategies used to apply each nonquantitative treatment
104 limitation, in operation, for benefits for behavioral, mental health, and substance use disorders
105 are comparable to, and are applied no more stringently than, the processes and strategies used
106 to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits;
107 and

108 (E) Disclose the specific findings and conclusions reached by the Insurance
109 Commissioner that the results of the analyses indicate that each health benefit plan offered
110 pursuant to this section complies with section (c) and this section.
111 (h) The Insurance Commission shall adopt legislative rules to comply with the provisions
112 of this section. These rules or amendments to rules shall be proposed pursuant to the provisions
113 of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the Legislature
114 during its regular session in the year 2021.
115 (i) This section is effective for policies, contracts, plans or agreements, beginning on or
116 after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject
117 to this article that are delivered, executed, issues, amended, adjusted, or renewed in this state on
118 or after the effective date of this section.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8r. Mental health parity.

1 (a) As used in this section, the following words and phrases have the meaning given them
2 in this section unless the context clearly indicates otherwise:
3 "Behavioral, Mental Health and Substance Use Disorder" means a condition or disorder,
4 regardless of etiology, that may be the result of a combination of genetic and environmental
5 factors and that falls under any of the diagnostic categories listed in the mental disorders section
6 of the most recent version of:
7 (1) The International Statistical Classification of Diseases and Related Health Problems;
8 (2) The Diagnostic and Statistical Manual of Mental Disorders; or
9 (3) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy
10 and Early Childhood; and
11 Includes autism spectrum disorder.
12 (b) The Carrier is required to provide coverage for the prevention of, screening for and

13 treatment of behavioral, mental health and substance use disorders that is no less extensive than
14 the coverage provided for any physical illness and that complies with the requirements of this
15 section. This screening shall include, but is not limited to, unhealthy alcohol use for adults,
16 substance use for adults and adolescents, and depression screening for adolescents and adults.

17 (c) The Carrier shall:

18 (1) Include coverage and reimbursement for behavioral health screenings using a
19 validated screening tool for behavioral health, which coverage and reimbursement is no less
20 extensive than the coverage and reimbursement for the annual physical examination.

21 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR
22 146.136 (c)(4), or any successor regulation, regarding any limitations that are not expressed
23 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to
24 the limitations and examples listed in 45 CFR 146.136 (c)(4)(ii) and (c)(4)(iii), or any successor
25 regulation and 78 FR 68246, include the methods by which the Carrier establishes and maintains
26 its provider network and responds to deficiencies in the ability of its networks to provide timely
27 access to care;

28 (3) Comply with the financial requirements and quantitative treatment limitations specified
29 in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation;

30 (4) Not apply any nonquantitative treatment limitations to benefits for behavioral, mental
31 health, and substance use disorders that are not applied to medical and surgical benefits within
32 the same classification of benefits;

33 (5) Establish procedures to authorize treatment with a nonparticipating provider if a
34 covered service is not available within established time and distance standards and within a
35 reasonable period after service is requested, and with the same coinsurance, deductible, or
36 copayment requirements as would apply if the service were provided at a participating provider,
37 and at no greater cost to the covered person than if the services were obtain at or form a
38 participating provider;

39 (6) If a covered person obtains a covered service from a nonparticipating provider because
40 the covered service is not available within the established time and distance standards, reimburse
41 treatment or services for behavioral, mental health, or substance use disorders required to be
42 covered pursuant to this subsection that are provided by a nonparticipating provider using the
43 same methodology that the Carrier uses to reimburse covered medical services provided by
44 nonparticipating providers and, upon request, provide evidence of the methodology to the person
45 or provider.
46 (d) If the Carrier offers a plan that does not cover services provided by an out-of-network
47 provider, it may provide the benefits required in subsection (c) if the services are rendered by a
48 provider who is designated by and affiliated with the Carrier only if the same requirements apply
49 for services for a physical illness;
50 (e) In the event of a concurrent review for a claim for coverage of services for the
51 prevention of, screening for, and treatment of behavioral, mental health, and substance use
52 disorders, the service continues to be a covered service until the Carrier notifies the covered
53 person of the determination of the claim;
54 (f) Unless denied for nonpayment of premium, a denial of reimbursement for services for
55 the prevention of, screening for, or treatment of behavioral, mental health, and substance use
56 disorders by the Carrier must include the following language:
57 (1) A statement explaining that covered persons are protected under this section, which
58 provides that limitations placed on the access to mental health and substance use disorder
59 benefits may be no greater than any limitations placed on access to medical and surgical benefits;
60 (2) A statement providing information about the Consumer Services Division of the Office
61 of the West Virginia Insurance Commissioner if the covered person believes his or her rights
62 under this section have been violated; and
63 (3) A statement specifying that covered persons are entitled, upon request to the Carrier,
64 to a copy of the medical necessity criteria for any behavioral, mental health, and substance use

65 disorder benefit.

66 (g) On or after June 1, 2021, and annually thereafter, the Insurance Commissioner shall
67 submit a written report to the Joint Committee on Government and Finance that contains the
68 following information regarding plans offered pursuant to this section:

69 (1) Data that demonstrates parity compliance for adverse determination regarding claims
70 for behavioral, mental health, or substance use disorder services and includes the total number
71 of adverse determinations for such claims;

72 (2) A description of the process used to develop and select:

73 (A) The medical necessity criteria used in determining benefits for behavioral health,
74 mental health, substance use disorders; and

75 (B) The medical necessity criteria used in determining medical and surgical benefits;

76 (3) Identification of all nonquantitative treatment limitations that are applied to benefits for
77 behavioral, mental health, and substance use disorders and to medical and surgical benefits
78 within each classification of benefits; and

79 (4)The results of analyses demonstrating that, for medical necessity criteria descried in
80 subsection (g)(2) of this section and for each nonquantitative treatment limitation identified in
81 subsection (g)(3) of this section, as written and in operation, the processes, strategies, evidentiary
82 standards, or other factors used in applying the medical necessity criteria and each
83 nonquantitative treatment limitation to benefits for behavioral, mental health, and substance use
84 disorders within each classification of benefits are comparable to, and are applied no more
85 stringently than, the processes, strategies, evidentiary standards, or other factors used in applying
86 the medical necessity criteria and each nonquantitative treatment limitation to medical and
87 surgical benefits within the corresponding classification of benefits.

88 (5) The Insurance Commissioner's report of the analyses regarding nonquantitative
89 treatment limitations shall include at a minimum:

90 (A) Identify factors used to determine whether a nonquantitative treatment limitation will

91 apply to a benefit, including factors that were considered but rejected;

92 (B) Identify and define the specific evidentiary standards used to define the factors and
93 any other evidence relied on in designing each nonquantitative treatment limitation;

94 (C) Provide the comparative analyses, including the results of the analyses, performed to
95 determine that the processes and strategies used to design each nonquantitative treatment
96 limitation, as written, and the written processes and strategies used to apply each nonquantitative
97 treatment limitation for benefits for behavioral, mental health, and substance use disorders are
98 comparable to, and are applied no more stringently than, the processes and strategies used to
99 design and apply each nonquantitative treatment limitation, as written, and the written processes
100 and strategies used to apply each nonquantitative treatment limitation for medical and surgical
101 benefits;

102 (D) Provide the comparative analysis, including the results of the analyses, performed to
103 determine that the processes and strategies used to apply each nonquantitative treatment
104 limitation, in operation, for benefits for behavioral, mental health, and substance use disorders
105 are comparable to, and are applied no more stringently than, the processes and strategies used
106 to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits;
107 and

108 (E) Disclose the specific findings and conclusions reached by the Insurance Commission
109 that the results of the analyses indicate that each health benefit plan offered pursuant to this
110 section complies with section (c) and this section.

111 (h) The Insurance Commission shall adopt legislative rules to comply with the provisions
112 of this section. These rules or amendments to rules shall be proposed pursuant to the provisions
113 of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the Legislature
114 during its regular session in the year 2021.

115 (i) This section is effective for policies, contracts, plans or agreements, beginning on or
116 after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject

117 to this article that are delivered, executed, issues, amended, adjusted, or renewed in this state on

118 or after the effective date of this section.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8u. Mental health parity.

1 (a) As used in this section, the following words and phrases have the meaning given them

2 in this section unless the context clearly indicates otherwise:

3 "Behavioral, Mental Health and Substance Use Disorder" means a condition or disorder,

4 regardless of etiology, that may be the result of a combination of genetic and environmental

5 factors and that falls under any of the diagnostic categories listed in the mental disorders section

6 of the most recent version of:

7 (1) The International Statistical Classification of Diseases and Related Health Problems;

8 (2) The Diagnostic and Statistical Manual of Mental Disorders; or

9 (3) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy

10 and Early Childhood; and

11 Includes autism spectrum disorder.

12 (b) The Carrier is required to provide coverage for the prevention of, screening for and

13 treatment of behavioral, mental health and substance use disorders that is no less extensive than

14 the coverage provided for any physical illness and that complies with the requirements of this

15 section. This screening shall include, but is not limited to. unhealthy alcohol use for adults,

16 substance use for adults and adolescents, and depression screening for adolescents and adults.

17 (c) The Carrier shall:

18 (1) Include coverage and reimbursement for behavioral health screenings using a

19 validated screening tool for behavioral health, which coverage and reimbursement is no less

20 extensive than the coverage and reimbursement for the annual physical examination.

21 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR

22 146.136 (c)(4), or any successor regulation, regarding any limitations that are not expressed
23 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to
24 the limitations and examples listed in 45 CFR 146.136 (c)(4)(ii) and (c)(4)(iii), or any successor
25 regulation and 78 FR 68246, include the methods by which the Carrier establishes and maintains
26 its provider network and responds to deficiencies in the ability of its networks to provide timely
27 access to care;

28 (3) Comply with the financial requirements and quantitative treatment limitations specified
29 in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation;

30 (4) Not apply any nonquantitative treatment limitations to benefits for behavioral, mental
31 health, and substance use disorders that are not applied to medical and surgical benefits within
32 the same classification of benefits;

33 (5) Establish procedures to authorize treatment with a nonparticipating provider if a
34 covered service is not available within established time and distance standards and within a
35 reasonable period after service is requested, and with the same coinsurance, deductible, or
36 copayment requirements as would apply if the service were provided at a participating provider,
37 and at no greater cost to the covered person than if the services were obtain at or form a
38 participating provider;

39 (6) If a covered person obtains a covered service from a nonparticipating provider because
40 the covered service is not available within the established time and distance standards, reimburse
41 treatment or services for behavioral, mental health, or substance use disorders required to be
42 covered pursuant to this subsection that are provided by a nonparticipating provider using the
43 same methodology that the Carrier uses to reimburse covered medical services provided by
44 nonparticipating providers and, upon request, provide evidence of the methodology to the person
45 or provider.

46 (d) If the Carrier offers a plan that does not cover services provided by an out-of-network
47 provider, it may provide the benefits required in subsection (c) if the services are rendered by a

48 provider who is designated by and affiliated with the Carrier only if the same requirements apply
49 for services for a physical illness;
50 (e) In the event of a concurrent review for a claim for coverage of services for the
51 prevention of, screening for, and treatment of behavioral, mental health, and substance use
52 disorders, the service continues to be a covered service until the Carrier notifies the covered
53 person of the determination of the claim;
54 (f) Unless denied for nonpayment of premium, a denial of reimbursement for services for
55 the prevention of, screening for, or treatment of behavioral, mental health, and substance use
56 disorders by the Carrier must include the following language:
57 (1) A statement explaining that covered persons are protected under this section, which
58 provides that limitations placed on the access to mental health and substance use disorder
59 benefits may be no greater than any limitations placed on access to medical and surgical benefits;
60 (2) A statement providing information about the Division of Consumer Services of the
61 Office of the West Virginia Insurance Commissioner if the covered person believes his or her
62 rights under this section have been violated; and
63 (3) A statement specifying that covered persons are entitled, upon request to the Carrier,
64 to a copy of the medical necessity criteria for any behavioral, mental health, and substance use
65 disorder benefit.
66 (g) On or after June 1, 2021, and annually thereafter, the Insurance Commissioner shall
67 submit a written report to the Joint Committee on Government and Finance that contains the
68 following information regarding plans offered pursuant to this section:
69 (1) Data that demonstrates parity compliance for adverse determination regarding claims
70 for behavioral, mental health, or substance use disorder services and includes the total number
71 of adverse determinations for such claims;
72 (2) A description of the process used to develop and select:
73 (A) The medical necessity criteria used in determining benefits for behavioral health,

74 mental health, and substance use disorders; and

75 (B) The medical necessity criteria used in determining medical and surgical benefits;

76 (3) Identification of all nonquantitative treatment limitations that are applied to benefits for

77 behavioral, mental health, and substance use disorders and to medical and surgical benefits

78 within each classification of benefits; and

79 (4)The results of analyses demonstrating that, for medical necessity criteria descried in

80 subsection (g)(2) of this section and for each nonquantitative treatment limitation identified in

81 subsection (g)(3) of this section, as written and in operation, the processes, strategies, evidentiary

82 standards, or other factors used in applying the medical necessity criteria and each

83 nonquantitative treatment limitation to benefits for behavioral, mental health, and substance use

84 disorders within each classification of benefits are comparable to, and are applied no more

85 stringently than, the processes, strategies, evidentiary standards, or other factors used in applying

86 the medical necessity criteria and each nonquantitative treatment limitation to medical and

87 surgical benefits within the corresponding classification of benefits.

88 (5) The Insurance Commission's report of the analyses regarding nonquantitative

89 treatment limitations shall include at a minimum:

90 (A) Identify factors used to determine whether a nonquantitative treatment limitation will

91 apply to a benefit, including factors that were considered but rejected;

92 (B) Identify and define the specific evidentiary standards used to define the factors and

93 any other evidence relied on in designing each nonquantitative treatment limitation;

94 (C) Provide the comparative analyses, including the results of the analyses, performed to

95 determine that the processes and strategies used to design each nonquantitative treatment

96 limitation, as written, and the written processes and strategies used to apply each nonquantitative

97 treatment limitation for benefits for behavioral, mental health, and substance use disorders are

98 comparable to, and are applied no more stringently than, the processes and strategies used to

99 design and apply each nonquantitative treatment limitation, as written, and the written processes

100 and strategies used to apply each nonquantitative treatment limitation for medical and surgical
101 benefits;
102 (D) Provide the comparative analysis, including the results of the analyses, performed to
103 determine that the processes and strategies used to apply each nonquantitative treatment
104 limitation, in operation, for benefits for behavioral, mental health, and substance use disorders
105 are comparable to, and are applied no more stringently than, the processes and strategies used
106 to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits;
107 and
108 (E) Disclose the specific findings and conclusions reached by the Insurance
109 Commissioner that the results of the analyses indicate that each health benefit plan offered
110 pursuant to this section complies with section (c) and this section.
111 (h) The Insurance Commission shall adopt legislative rules to comply with the provisions
112 of this section. These rules or amendments to rules shall be proposed pursuant to the provisions
113 of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the Legislature
114 during its regular session in the year 2021.
115 (i) This section is effective for policies, contracts, plans or agreements, beginning on or
116 after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject
117 to this article that are delivered, executed, issues, amended, adjusted, or renewed in this state on
118 or after the effective date of this section.

NOTE: The purpose of this bill is to require the Public Employees Insurance Agency and other health insurance providers provide mental health parity between behavioral health, mental health, substance use disorders and medical and surgical procedures.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.