WEST VIRGINIA LEGISLATURE

2020 REGULAR SESSION

Enrolled

Committee Substitute

for

Committee Substitute

for

Senate Bill 291

SENATORS WELD AND WOELFEL, *original sponsors*

[Passed March 7, 2020; in effect 90 days from passage]

AN ACT to repeal §33-15-4a of the Code of West Virginia, 1931, as amended; to repeal §33-16-3a of said code; to amend and reenact §5-16-7 of said code; to amend said code by adding thereto a new section, designated §33-15-4u; to amend said code by adding thereto a new section, designated §33-16-3ff; to amend and reenact §33-24-4 of said code; to amend said code by adding thereto a new section, designated §33-24-7u; to amend and reenact §33-25-6 of said code; to amend said code by adding thereto a new section, designated §33-25-8r; and to amend said code by adding thereto a new section, designated §33-25A-8u, all relating to requiring the Public Employees Insurance Agency and other health insurance providers to provide mental health parity between behavioral health, mental health, substance use disorders, and medical and surgical procedures; providing definitions; providing for mandatory 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.

§5-16-7. Authorization to establish group hospital and surgical insurance plan, group major medical insurance plan, group prescription drug plan, and group life and accidental death insurance plan; rules for administration of plans; mandated benefits; what plans may provide; optional plans; separate rating for claims experience purposes.

(a) The agency shall establish a group hospital and surgical insurance plan or plans, a group prescription drug insurance plan or plans, a group major medical insurance plan or plans,

and a group life and accidental death insurance plan or plans for those employees herein made eligible and establish and promulgate rules for the administration of these plans subject to the limitations contained in this article. These plans shall include:

(1) Coverages and benefits for x-ray and laboratory services in connection with mammograms when medically appropriate and consistent with current guidelines from the United States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or the American College of Obstetricians and Gynecologists; and a test for the human papilloma virus when medically appropriate and consistent with current guidelines from either the United States Preventive Services Task Force or the American College of Obstetricians and Gynecologists, when performed for cancer screening or diagnostic services on a woman age 18 or over;

(2) Annual checkups for prostate cancer in men age 50 and over;

(3) Annual screening for kidney disease as determined to be medically necessary by a physician using any combination of blood pressure testing, urine albumin or urine protein testing, and serum creatinine testing as recommended by the National Kidney Foundation;

(4) For plans that include maternity benefits, coverage for inpatient care in a duly licensed health care facility for a mother and her newly born infant for the length of time which the attending physician considers medically necessary for the mother or her newly born child. No plan may deny payment for a mother or her newborn child prior to 48 hours following a vaginal delivery or prior to 96 hours following a caesarean section delivery if the attending physician considers discharge medically inappropriate;

(5) For plans which provide coverages for post-delivery care to a mother and her newly born child in the home, coverage for inpatient care following childbirth as provided in subdivision (4) of this section if inpatient care is determined to be medically necessary by the attending physician. These plans may include, among other things, medicines, medical equipment,

prosthetic appliances, and any other inpatient and outpatient services and expenses considered appropriate and desirable by the agency; and

(6) Coverage for treatment of serious mental illness:

(A) The coverage does not include custodial care, residential care, or schooling. For purposes of this section, “serious mental illness” means an illness included in the American Psychiatric Association’s diagnostic and statistical manual of mental disorders, as periodically revised, under the diagnostic categories or subclassifications of: (i) Schizophrenia and other psychotic disorders; (ii) bipolar disorders; (iii) depressive disorders; (iv) substance-related disorders with the exception of caffeine-related disorders and nicotine-related disorders; (v) anxiety disorders; and (vi) anorexia and bulimia. With regard to a covered individual who has not yet attained the age of 19 years, “serious mental illness” also includes attention deficit hyperactivity disorder, separation anxiety disorder, and conduct disorder.

(B)The agency shall not discriminate between medical-surgical benefits and mental health benefits in the administration of its plan. With regard to both medical-surgical and mental health benefits, it may make determinations of medical necessity and appropriateness and it may use recognized health care quality and cost management tools including, but not limited to, limitations on inpatient and outpatient benefits, utilization review, implementation of cost-containment measures, preauthorization for certain treatments, setting coverage levels, setting maximum number of visits within certain time periods, using capitated benefit arrangements, using fee-for-service arrangements, using third-party administrators, using provider networks, and using patient cost sharing in the form of copayments, deductibles, and coinsurance. Additionally, the agency shall comply with the financial requirements and quantitative treatment limitations specified in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation. The agency may not apply any nonquantitative treatment limitations to benefits for behavioral health, mental health, and substance use disorders that are not applied to medical and surgical benefits within the same classification of benefits: *Provided,* That any service, even if it is related to the behavioral health,

mental health, or substance use diagnosis if medical in nature, shall be reviewed as a medical claim and undergo all utilization review as applicable;

(7) Coverage for general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care if the covered person is:

(A) Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the individual and for whom a superior result can be expected from dental care provided under general anesthesia.

(B) A child who is 12 years of age or younger with documented phobias or with documented mental illness and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth, or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

(8) (A) Any plan issued or renewed on or after January 1, 2012, shall include coverage for diagnosis, evaluation, and treatment of autism spectrum disorder in individuals ages 18 months to 18 years. To be eligible for coverage and benefits under this subdivision, the individual must be diagnosed with autism spectrum disorder at age eight or younger. Such plan shall provide coverage for treatments that are medically necessary and ordered or prescribed by a licensed physician or licensed psychologist and in accordance with a treatment plan developed from a comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism spectrum disorder.

(B) The coverage shall include, but not be limited to, applied behavior analysis which shall be provided or supervised by a certified behavior analyst. The annual maximum benefit for applied

behavior analysis required by this subdivision shall be in an amount not to exceed $30,000 per individual for three consecutive years from the date treatment commences. At the conclusion of the third year, coverage for applied behavior analysis required by this subdivision shall be in an amount not to exceed $2,000 per month, until the individual reaches 18 years of age, as long as the treatment is medically necessary and in accordance with a treatment plan developed by a certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual. This subdivision does not limit, replace, or affect any obligation to provide services to an individual under the Individuals with Disabilities Education Act, 20 U. S. C. §1400 *et seq.*, as amended from time to time, or other publicly funded programs. Nothing in this subdivision requires reimbursement for services provided by public school personnel.

(C) The certified behavior analyst shall file progress reports with the agency semiannually. In order for treatment to continue, the agency must receive objective evidence or a clinically supportable statement of expectation that:

(i) The individual's condition is improving in response to treatment;

(ii) A maximum improvement is yet to be attained; and

(iii) There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

(D) On or before January 1 each year, the agency shall file an annual report with the Joint Committee on Government and Finance describing its implementation of the coverage provided pursuant to this subdivision. The report shall include, but not be limited to, the number of individuals in the plan utilizing the coverage required by this subdivision, the fiscal and administrative impact of the implementation and any recommendations the agency may have as to changes in law or policy related to the coverage provided under this subdivision. In addition, the agency shall provide such other information as required by the Joint Committee on Government and Finance as it may request.

(E) For purposes of this subdivision, the term:

(i) “Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences in order to produce socially significant improvement in human behavior and includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(ii) “Autism spectrum disorder” means any pervasive developmental disorder including autistic disorder, Asperger’s syndrome, Rett syndrome, childhood disintegrative disorder, or Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(iii) “Certified behavior analyst” means an individual who is certified by the Behavior Analyst Certification Board or certified by a similar nationally recognized organization.

(iv) “Objective evidence” means standardized patient assessment instruments, outcome measurements tools, or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during, and after treatment is recommended to quantify progress and support justifications for continued treatment. The tools are not required but their use will enhance the justification for continued treatment.

(F)To the extent that the provisions of this subdivision require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of insurance plans offered by the Public Employees Insurance Agency.

(9) For plans that include maternity benefits, coverage for the same maternity benefits for all individuals participating in or receiving coverage under plans that are issued or renewed on or after January 1, 2014: *Provided,* That to the extent that the provisions of this subdivision require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that

exceed the specified essential health benefits shall not be required of a health benefit plan when the plan is offered in this state.

(10) (A) A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that is subject to this section, shall provide coverage, through the age of 20, for amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state pursuant to either §30-3-1 *et seq.* or §30-14-1 *et seq.* of this code:

(i) Immunoglobulin E and nonimmunoglobulin E-medicated allergies to multiple food proteins;

(ii) Severe food protein-induced enterocolitis syndrome;

(iii) Eosinophilic disorders as evidenced by the results of a biopsy; and

(iv) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract (short bowel).

(B) The coverage required by paragraph (A) of this subdivision shall include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary, regardless of methodology of delivery.

(C) For purposes of this subdivision, “medically necessary foods” or “medical foods” shall mean prescription amino acid-based elemental formulas obtained through a pharmacy: *Provided,* That these foods are specifically designated and manufactured for the treatment of severe allergic conditions or short bowel.

(D) The provisions of this subdivision shall not apply to persons with an intolerance for lactose or soy.

(b) The agency shall, with full authorization, make available to each eligible employee, at full cost to the employee, the opportunity to purchase optional group life and accidental death

insurance as established under the rules of the agency. In addition, each employee is entitled to have his or her spouse and dependents, as defined by the rules of the agency, included in the optional coverage, at full cost to the employee, for each eligible dependent.

(c) The finance board may cause to be separately rated for claims experience purposes:

(1) All employees of the State of West Virginia;

(2) All teaching and professional employees of state public institutions of higher education and county boards of education;

(3) All nonteaching employees of the Higher Education Policy Commission, West Virginia Council for Community and Technical College Education, and county boards of education; or

(4) Any other categorization which would ensure the stability of the overall program.

(d) The agency shall maintain the medical and prescription drug coverage for Medicare-eligible retirees by providing coverage through one of the existing plans or by enrolling the Medicare-eligible retired employees into a Medicare-specific plan, including, but not limited to, the Medicare/Advantage Prescription Drug Plan. If a Medicare-specific plan is no longer available or advantageous for the agency and the retirees, the retirees remain eligible for coverage through the agency.

(e) The agency shall 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 obtained at or from a participating provider.

(f) If the Public Employees Insurance Agency offers a plan that does not cover services provided by an out-of-network provider, it may provide the benefits required in paragraph (A), subdivision (6), subsection (a) of this section if the services are rendered by a provider who is

designated by and affiliated with the Public Employees Insurance Agency, and only if the same requirements apply for services for a physical illness.

(g) In the event of a concurrent review for a claim for coverage of services for the prevention of, screening for, and treatment of behavioral health, mental health, and substance use disorders, the service continues to be a covered service until the Public Employees Insurance Agency notifies the covered person of the determination of the claim.

(h) Unless denied for nonpayment of premium, a denial of reimbursement for services for the prevention of, screening for, or treatment of behavioral health, mental health, and substance use disorders by the Public Employees Insurance Agency shall include the following language:

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

(2) A statement providing information about the internal appeals process if the covered person believes his or her rights under this section have been violated; and

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

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

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

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

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

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

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

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

(5) The Public Employees Insurance Agency's report of the analyses regarding nonquantitative treatment limitations shall include at a minimum:

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

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

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

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

(E) Disclose the specific findings and conclusions reached by the Public Employees Insurance Agency that the results of the analyses indicate that each health benefit plan offered by the Public Employees Insurance Agency complies with paragraph (B), subdivision (6), subsection (a) of this section.

(6) After the initial report required by this subsection, annual reports are only required for any year thereafter during which the Public Employees Insurance Agency makes significant changes to how it designs and applies medical management protocols.

(j) The Public Employees Insurance Agency shall update its annual plan document to reflect its comprehensive parity compliance. An annual report shall also be filed with the Joint Committee on Government and Finance and the Public Employees Insurance Agency Finance Board.

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

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4a. Required policy provisions-mental illness.

[Repealed.]

§33-15-4u. Mental health parity.

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

To the extent that coverage is provided "behavioral health, mental health, and substance use disorder" means a condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of:

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

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

(C) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood; and

Includes autism spectrum disorder: *Provided,* That any service, even if it is related to the behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall be reviewed as a medical claim and undergo all utilization review as applicable.

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

(c) The carrier shall:

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

(2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR §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 health, 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 obtained at, or from a participating provider; and

(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 health, 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) of this section if the services are rendered by a provider who is designated by and affiliated with the carrier only if the same requirements apply for services for a physical illness.

(e) In the event of a concurrent review for a claim for coverage of services for the prevention of, screening for, and treatment of behavioral health, mental health, and substance

use disorders, the service continues to be a covered service until the carrier notifies the covered person of the determination of the claim.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) The Insurance Commissioner shall adopt legislative rules to comply with the provisions of this section. These rules shall specify the information and analyses that carriers shall provide to the Insurance Commissioner necessary for the Insurance Commissioner to complete the report described in subsection (g) of this section and shall delineate the format in which the carriers shall submit such information and analyses. These rules or amendments to rules shall be proposed pursuant to the provisions of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the Legislature during its regular session in the year 2021. The rules shall require that each carrier first submit the report to the Insurance Commissioner no earlier than one year after the rules are promulgated, and any year thereafter during which the carrier makes significant changes to how it designs and applies medical management protocols.

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

(j) The Insurance Commissioner shall enforce this section and may conduct a financial examination of the carrier to determine if it is in compliance with this section, including, but not limited to, a review of policies and procedures and a sample of mental health claims to determine

these claims are treated in parity with medical and surgical benefits. The results of this examination shall be reported to the Legislature. If the Insurance Commissioner determines that the carrier is not in compliance with this section, the Insurance Commissioner may fine the carrier in conformity with the fines established in the legislative rule.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3a. Same-mental health.

[Repealed.]

§33-16-3ff. Mental health parity.

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

To the extent that coverage is provided "behavioral, mental health, and substance use disorder" means a condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of:

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

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

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

Includes autism spectrum disorder: *Provided,* That any service, even if it is related to the behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall be reviewed as a medical claim and undergo all utilization review as applicable.

(b) The carrier is required to provide coverage for the prevention of, screening for, and treatment of behavioral health, mental health, and substance use disorders that is no less extensive than the coverage provided for any physical illness and that complies with the requirements of this section. This screening shall include but is not limited to unhealthy alcohol

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

(c) The carrier shall:

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

(2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR §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 health, 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 obtained at, or from a participating provider; and

(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 health, 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) of this section if the services are rendered by a provider who is designated by and affiliated with the carrier only if the same requirements apply for services for a physical illness.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) The Insurance Commissioner shall adopt legislative rules to comply with the provisions of this section. These rules shall specify the information and analyses that carriers shall provide to the Insurance Commissioner necessary for the commissioner to complete the report described in subsection (g) of this section and shall delineate the format in which carriers shall submit such information and analyses. These rules or amendments to rules shall be proposed pursuant to the provisions of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the Legislature during its regular session in the year 2021. The rules shall require that each carrier

first submit the report to the Insurance Commissioner no earlier than one year after the rules are promulgated, and any year thereafter during which the carrier makes significant changes to how it designs and applies medical management protocols.

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

(j) The Insurance Commissioner shall enforce this section and may conduct a financial examination of the carrier to determine if it is in compliance with this section, including, but not limited to, a review of policies and procedures and a sample of mental health claims to determine these claims are treated in parity with medical and surgical benefits. The results of this examination shall be reported to the Legislature. If the Insurance Commissioner determines that the carrier is not in compliance with this section, the Insurance Commissioner may fine the carrier in conformity with the fines established in the legislative rule.

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

§33-24-4. Exemptions; applicability of insurance laws.

(a) Every corporation defined in §33-24-2 of this code is hereby declared to be a scientific, nonprofit institution and exempt from the payment of all property and other taxes. Every corporation, to the same extent the provisions are applicable to insurers transacting similar kinds of insurance and not inconsistent with the provisions of this article, shall be governed by and be subject to the provisions as herein below indicated, of the following articles of this chapter: §33-2-1 *et seq.* of this code (Insurance Commissioner); §33-4-1 *et seq.* of this code (general provisions), except that §33-4-16 of this code may not be applicable thereto; §33-5-20 of this code

(borrowing by insurers); §33-6-34 of this code (fee for form, rate and rule filing); §33-6C-1 *et seq.* of this code (guaranteed loss ratios as applied to individual sickness and accident insurance policies); §33-7-1 *et seq.* of this code (assets and liabilities); §33-8A-1 *et seq.* of this code (use of clearing corporations and Federal Reserve book-entry system); §33-11-1 *et seq.* of this code (unfair trade practices); §33-12-1 *et seq.* of this code (insurance producers and solicitors), except that the agent's license fee shall be $25; §33-15-2a of this code (definitions); §33-15-2b of this code (guaranteed issue; limitation of coverage; election; denial of coverage; network plans); §33-15-2d of this code (exceptions to guaranteed renewability); §33-15-2e of this code (discontinuation of particular type of coverage; uniform termination of all coverage; uniform modification of coverage); §33-15-2f of this code (certification of creditable coverage); §33-15-2g (applicability); §33-15-4e of this code (benefits for mothers and newborns); §33-15-14 of this code (policies discriminating among health care providers); §33-15-16 of this code (policies not to exclude insured's children from coverage; required services; coordination with other insurance); §33-15-18 of this code (equal treatment of state agency); §33-15-19 of this code (coordination of benefits with Medicaid); §33-15A-1 *et seq.* of this code (West Virginia Long-Term Care Insurance Act); §33-15C-1 *et seq.* of this code (diabetes insurance); §33-16-3 of this code (required policy provisions); §33-16-3a of this code (same - mental health); §33-16-3d of this code (Medicare supplement insurance); §33-16-3f of this code (required policy provisions - treatment of temporomandibular joint disorder and craniomandibular disorder); §33-16-3j of this code (hospital benefits for mothers and newborns); §33-16-3k of this code (limitations on preexisting condition exclusions for health benefit plans); §33-16-3l of this code (renewability and modification of health benefit plans); §33-16-3m of this code (creditable coverage); §33-16-3n of this code (eligibility for enrollment); §33-16-11 of this code (group policies not to exclude insured's children from coverage; required services; coordination with other insurance); §33-16-13 of this code (equal treatment of state agency); §33-16-14 of this code (coordination of benefits with Medicaid); §33-16-16 of this code (insurance for diabetics); §33-16A-1 *et seq.* of this code (group health insurance

conversion); §33-16C-1 *et seq.* of this code (employer group accident and sickness insurance policies); §33-16D-1 *et seq.* of this code (marketing and rate practices for small employer accident and sickness insurance policies); §33-26A-1 *et seq.* of this code (West Virginia Life and Health Insurance Guaranty Association Act), after October 1, 1991, §33-27-1 *et seq.* of this code (insurance holding company systems); §33-28-1 *et seq.* of this code (individual accident and sickness insurance minimum standards); §33-33-1 *et seq.* of this code (annual audited financial report); §33-34-1 *et seq.* of this code (administrative supervision); §33-34A-1 *et seq.* of this code (standards and commissioner's authority for companies considered to be in hazardous financial condition); §33-35-1 *et seq.* of this code (criminal sanctions for failure to report impairment); §33-37-1 *et seq.* of this code (managing general agents); §33-40A-1 *et seq.* of this code (risk-based capital for health organizations); and §33-41-1 *et seq.* of this code (Insurance Fraud Prevention Act) and no other provision of this chapter may apply to these corporations unless specifically made applicable by the provisions of this article. If, however, the corporation is converted into a corporation organized for a pecuniary profit or if it transacts business without having obtained a license as required by §33-24-5 of this code, it shall thereupon forfeit its right to these exemptions.

(b) Every corporation subject to this article shall comply with mental health parity requirements in this chapter.

§33-24-7u. Mental health parity.

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

To the extent that coverage is provided "behavioral health, mental health, and substance use disorder" means a condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of:

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

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

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

Includes autism spectrum disorder: *Provided*, That any service, even if it is related to the behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall be reviewed as a medical claim and undergo all utilization review as applicable.

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

(c) The carrier shall:

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

(2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR §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 health, 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;

(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 health, 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) of this section if the services are rendered by a provider who is designated by and affiliated with the carrier only if the same requirements apply for services for a physical illness.

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

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

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

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

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

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

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

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

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

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

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

(4) The results of analyses demonstrating that, for medical necessity criteria described in subdivision (2) of this subsection and for each nonquantitative treatment limitation identified in subdivision (3) of this subsection, as written and in operation, the processes, strategies,

evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to benefits for behavioral health, mental health, and substance use disorders within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits.

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

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

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

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

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

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

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

(h) The Insurance Commissioner shall adopt legislative rules to comply with the provisions of this section. These rules shall specify the information and analyses that carriers shall provide to the Insurance Commissioner necessary for the commissioner to complete the report described in subsection (g) of this section and shall delineate the format in which carriers shall submit such information and analyses. These rules or amendments to rules shall be proposed pursuant to the provisions of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the Legislature during its regular session in the year 2021. The rules shall require that each carrier first submit the report to the Insurance Commissioner no earlier than one year after the rules are promulgated, and any year thereafter during which the carrier makes significant changes to how it designs and applies medical management protocols.

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

(j) The Insurance Commissioner shall enforce this section and may conduct a financial examination of the carrier to determine if it is in compliance with this section, including, but not limited to, a review of policies and procedures and a sample of mental health claims to determine these claims are treated in parity with medical and surgical benefits. The results of this examination shall be reported to the Legislature. If the Insurance Commissioner determines that

the carrier is not in compliance with this section, the Insurance Commissioner may fine the carrier in conformity with the fines established in the legislative rule.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-6. Supervision and regulation by Insurance Commissioner; exemption from insurance laws.

(a) Corporations organized under this article are subject to supervision and regulation of the Insurance Commissioner. The corporations organized under this article, to the same extent these provisions are applicable to insurers transacting similar kinds of insurance and not inconsistent with the provisions of this article, shall be governed by and be subject to the provisions as herein below indicated of the following articles of this chapter: §33-4-1 *et seq.* of this code (general provisions), except that §33-4-16 of this code shall not be applicable thereto; §33-6C-1 *et seq.* of this code (guaranteed loss ratio); §33-7-1 *et seq.* of this code (assets and liabilities); §33-8-1 *et seq.* of this code (investments); §33-10-1 *et seq.* of this code (rehabilitation and liquidation); §33-15-2a of this code (definitions); §33-15-2b of this code (guaranteed issue); §33-15-2d of this code (exception to guaranteed renewability); §33-15-2e of this code (discontinuation of coverage); §33-15-2f of this code (certification of creditable coverage); §33-15-2g of this code (applicability); §33-15-4e of this code (benefits for mothers and newborns); §33-15-14 of this code (individual accident and sickness insurance); §33-15-16 of this code (coverage of children); §33-15-18 of this code (equal treatment of state agency); §33-15-19 of this code (coordination of benefits with Medicaid); §33-15C-1 of this code (diabetes insurance); §33-16-3 of this code (required policy provisions); §33-16-3a of this code (mental health); §33-16-3j of this code (benefits for mothers and newborns); §33-16-3k of this code (preexisting condition exclusions); §33-16-3l of this code (guaranteed renewability); §33-16-3m of this code (creditable coverage); §33-16-3n of this code (eligibility for enrollment); §33-16-11 of this code (coverage of children); §33-16-13 of this code (equal treatment of state agency); §33-16-14 of

this code (coordination of benefits with Medicaid); §33-16-16 of this code (diabetes insurance); §33-16A-1 *et seq.* of this code (group health insurance conversion); §33-16C-1 *et seq.* of this code (small employer group policies); §33-16D-1 *et seq.* of this code (marketing and rate practices for small employers); §33-25F-1 *et seq.* of this code (coverage for patient cost of clinical trials); §33-26A-1 *et seq.* of this code (West Virginia Life and Health Insurance Guaranty Association Act); §33-27-1 *et seq.* of this code (insurance holding company systems); §33-33-1 *et seq.* of this code (annual audited financial report); §33-34A-1 *et seq.* of this code (standards and commissioner's authority for companies considered to be in hazardous financial condition); §33-35-1 *et seq.* of this code (criminal sanctions for failure to report impairment); §33-37-1 *et seq.* of this code (managing general agents); §33-40A-1 *et seq.* of this code (risk-based capital for health organizations); and §33-41-1 *et seq.* of this code (privileges and immunity); and no other provision of this chapter may apply to these corporations unless specifically made applicable by the provisions of this article.

(b) Every corporation subject to this article shall comply with mental health parity requirements in this chapter.

§33-25-8r. Mental health parity.

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

To the extent that coverage is provided "behavioral health, mental health, and substance use disorder" means a condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of:

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

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

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

Includes autism spectrum disorder: *Provided*, That any service, even if it is related to the behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall be reviewed as a medical claim and undergo all utilization review as applicable.

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

(c) The carrier shall:

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

(2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR §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 health, 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 obtained at, or from a participating provider; and

(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 health, 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) of this section if the services are rendered by a provider who is designated by and affiliated with the carrier only if the same requirements apply for services for a physical illness.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for benefits for behavioral health, mental health, and substance use

disorders are comparable to, and are applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

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

(h) The Insurance Commissioner shall adopt legislative rules to comply with the provisions of this section. These rules shall specify the information and analyses that carriers shall provide to the Insurance Commissioner necessary for the commissioner to complete the report described in subsection (g) of this section and shall delineate the format in which carriers shall submit such information and analyses. These rules or amendments to rules shall be proposed pursuant to the provisions of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the Legislature during its regular session in the year 2021. The rules shall require that each carrier first submit the report to the Insurance Commissioner no earlier than one year after the rules are promulgated, and any year thereafter during which the carrier makes significant changes to how it designs and applies medical management protocols.

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

(j) The Insurance Commissioner shall enforce this section and may conduct a financial examination of the carrier to determine if it is in compliance with this section, including, but not limited to, a review of policies and procedures and a sample of mental health claims to determine these claims are treated in parity with medical and surgical benefits. The results of this examination shall be reported to the Legislature. If the Insurance Commissioner determines that

the carrier is not in compliance with this section, the Insurance Commissioner may fine the carrier in conformity with the fines established in the legislative rule.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8u. Mental health parity.

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

To the extent that coverage is provided "behavioral health, mental health, and substance use disorder" means a condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of:

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

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

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

Includes autism spectrum disorder: *Provided*, That any service, even if it is related to the behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall be reviewed as a medical claim and undergo all utilization review as applicable.

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

(c) The carrier shall:

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

(2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR §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 health, 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 obtained at, or from 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 health, 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) of this section if the services are rendered by a provider who is designated by and affiliated with the carrier only if the same requirements apply for services for a physical illness.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) The Insurance Commissioner shall adopt legislative rules to comply with the provisions of this section. These rules shall specify the information and analyses that carriers shall provide to the Insurance Commissioner necessary for the commissioner to complete the report described in subsection (g) of this section and shall delineate the format in which carriers shall submit such information and analyses. These rules or amendments to rules shall be proposed pursuant to the provisions of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the Legislature during its regular session in the year 2021. The rules shall require that each carrier first submit the report to the Insurance Commissioner no earlier than one year after the rules are

promulgated, and any year thereafter during which the carrier makes significant changes to how it designs and applies medical management protocols.

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

(j) The Insurance Commissioner shall enforce this section and may conduct a financial examination of the carrier to determine if it is in compliance with this section, including, but not limited to, a review of policies and procedures and a sample of mental health claims to determine these claims are treated in parity with medical and surgical benefits. The results of this examination shall be reported to the Legislature. If the Insurance Commissioner determines that the carrier is not in compliance with this section, the Insurance Commissioner may fine the carrier in conformity with the fines established in the legislative rule.

The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

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Chairman, Senate Committee

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Chairman, House Committee

Originated in the Senate.

In effect 90 days from passage.

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Clerk of the Senate

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Clerk of the House of Delegates

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President of the Senate

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Speaker of the House of Delegates

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The within ..... this the.....

Day of ....., 2020.

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Governor