

# WEST VIRGINIA LEGISLATURE

## 2020 REGULAR SESSION

**Enrolled**  
**Committee Substitute**  
**for**  
**Committee Substitute**  
**for**  
**Senate Bill 291**

OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE

2020 MAR 25 P 3:53

FILED

SENATORS WELD AND WOELFEL, *original sponsors*

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

SB 291

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1 AN ACT to repeal §33-15-4a of the Code of West Virginia, 1931, as amended; to repeal §33-16-  
2 3a of said code; to amend and reenact §5-16-7 of said code; to amend said code by adding  
3 thereto a new section, designated §33-15-4u; to amend said code by adding thereto a  
4 new section, designated §33-16-3ff; to amend and reenact §33-24-4 of said code; to  
5 amend said code by adding thereto a new section, designated §33-24-7u; to amend and  
6 reenact §33-25-6 of said code; to amend said code by adding thereto a new section,  
7 designated §33-25-8r; and to amend said code by adding thereto a new section,  
8 designated §33-25A-8u, all relating to requiring the Public Employees Insurance Agency  
9 and other health insurance providers to provide mental health parity between behavioral  
10 health, mental health, substance use disorders, and medical and surgical procedures;  
11 providing definitions; providing for mandatory reporting; providing for rulemaking; and  
12 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.**

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

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

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

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

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

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

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

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

31 (6) Coverage for treatment of serious mental illness:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

143 (ii) Severe food protein-induced enterocolitis syndrome;

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

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

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

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

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

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

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

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

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

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

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

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

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

174 (e) The agency shall establish procedures to authorize treatment with a nonparticipating  
175 provider if a covered service is not available within established time and distance standards and  
176 within a reasonable period after service is requested, and with the same coinsurance, deductible,  
177 or copayment requirements as would apply if the service were provided at a participating provider,  
178 and at no greater cost to the covered person than if the services were obtained at or from a  
179 participating provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

253 (k) This section is effective for policies, contracts, plans or agreements, beginning on or  
254 after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject  
255 to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
256 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.**

1 [Repealed.]

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

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

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

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

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

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

20 (c) The carrier shall:

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

24 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR  
25 §146.136(c)(4), or any successor regulation, regarding any limitations that are not expressed  
26 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to  
27 the limitations and examples listed in 45 CFR §146.136(c)(4)(ii) and (c)(4)(iii), or any successor  
28 regulation and 78 FR 68246, include the methods by which the carrier establishes and maintains

29 its provider network and responds to deficiencies in the ability of its networks to provide timely  
30 access to care;

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

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

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

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

49 (d) If the carrier offers a plan that does not cover services provided by an out-of-network  
50 provider, it may provide the benefits required in subsection (c) of this section if the services are  
51 rendered by a provider who is designated by and affiliated with the carrier only if the same  
52 requirements apply for services for a physical illness.

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

**ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.**

**§33-16-3a. Same-mental health.**

1 [Repealed.]

**§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 To the extent that coverage is provided “behavioral, mental health, and substance use  
4 disorder” means a condition or disorder, regardless of etiology, that may be the result of a  
5 combination of genetic and environmental factors and that falls under any of the diagnostic  
6 categories listed in the mental disorders section 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: *Provided*, That any service, even if it is related to the  
12 behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall  
13 be reviewed as a medical claim and undergo all utilization review as applicable.

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

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

20 (c) The carrier shall:

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

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

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

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

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

42 (6) If a covered person obtains a covered service from a nonparticipating provider because  
43 the covered service is not available within the established time and distance standards, reimburse

44 treatment or services for behavioral health, mental health, or substance use disorders required to  
45 be covered pursuant to this subsection that are provided by a nonparticipating provider using the  
46 same methodology that the carrier uses to reimburse covered medical services provided by  
47 nonparticipating providers and, upon request, provide evidence of the methodology to the person  
48 or provider.

49 (d) If the carrier offers a plan that does not cover services provided by an out-of-network  
50 provider, it may provide the benefits required in subsection (c) of this section if the services are  
51 rendered by a provider who is designated by and affiliated with the carrier only if the same  
52 requirements apply for services for a physical illness.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

128 (j) The Insurance Commissioner shall enforce this section and may conduct a financial  
129 examination of the carrier to determine if it is in compliance with this section, including, but not  
130 limited to, a review of policies and procedures and a sample of mental health claims to determine  
131 these claims are treated in parity with medical and surgical benefits. The results of this  
132 examination shall be reported to the Legislature. If the Insurance Commissioner determines that  
133 the carrier is not in compliance with this section, the Insurance Commissioner may fine the carrier  
134 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.**

1 (a) Every corporation defined in §33-24-2 of this code is hereby declared to be a scientific,  
2 nonprofit institution and exempt from the payment of all property and other taxes. Every  
3 corporation, to the same extent the provisions are applicable to insurers transacting similar kinds  
4 of insurance and not inconsistent with the provisions of this article, shall be governed by and be  
5 subject to the provisions as herein below indicated, of the following articles of this chapter: §33-  
6 2-1 *et seq.* of this code (Insurance Commissioner); §33-4-1 *et seq.* of this code (general  
7 provisions), except that §33-4-16 of this code may not be applicable thereto; §33-5-20 of this code



8 (borrowing by insurers); §33-6-34 of this code (fee for form, rate and rule filing); §33-6C-1 *et seq.*  
9 of this code (guaranteed loss ratios as applied to individual sickness and accident insurance  
10 policies); §33-7-1 *et seq.* of this code (assets and liabilities); §33-8A-1 *et seq.* of this code (use of  
11 clearing corporations and Federal Reserve book-entry system); §33-11-1 *et seq.* of this code  
12 (unfair trade practices); §33-12-1 *et seq.* of this code (insurance producers and solicitors), except  
13 that the agent's license fee shall be \$25; §33-15-2a of this code (definitions); §33-15-2b of this  
14 code (guaranteed issue; limitation of coverage; election; denial of coverage; network plans); §33-  
15 15-2d of this code (exceptions to guaranteed renewability); §33-15-2e of this code  
16 (discontinuation of particular type of coverage; uniform termination of all coverage; uniform  
17 modification of coverage); §33-15-2f of this code (certification of creditable coverage); §33-15-2g  
18 (applicability); §33-15-4e of this code (benefits for mothers and newborns); §33-15-14 of this code  
19 (policies discriminating among health care providers); §33-15-16 of this code (policies not to  
20 exclude insured's children from coverage; required services; coordination with other insurance);  
21 §33-15-18 of this code (equal treatment of state agency); §33-15-19 of this code (coordination of  
22 benefits with Medicaid); §33-15A-1 *et seq.* of this code (West Virginia Long-Term Care Insurance  
23 Act); §33-15C-1 *et seq.* of this code (diabetes insurance); §33-16-3 of this code (required policy  
24 provisions); §33-16-3a of this code (same - mental health); §33-16-3d of this code (Medicare  
25 supplement insurance); §33-16-3f of this code (required policy provisions - treatment of  
26 temporomandibular joint disorder and craniomandibular disorder); §33-16-3j of this code (hospital  
27 benefits for mothers and newborns); §33-16-3k of this code (limitations on preexisting condition  
28 exclusions for health benefit plans); §33-16-3l of this code (renewability and modification of health  
29 benefit plans); §33-16-3m of this code (creditable coverage); §33-16-3n of this code (eligibility for  
30 enrollment); §33-16-11 of this code (group policies not to exclude insured's children from  
31 coverage; required services; coordination with other insurance); §33-16-13 of this code (equal  
32 treatment of state agency); §33-16-14 of this code (coordination of benefits with Medicaid); §33-  
33 16-16 of this code (insurance for diabetics); §33-16A-1 *et seq.* of this code (group health insurance

34 conversion); §33-16C-1 *et seq.* of this code (employer group accident and sickness insurance  
35 policies); §33-16D-1 *et seq.* of this code (marketing and rate practices for small employer accident  
36 and sickness insurance policies); §33-26A-1 *et seq.* of this code (West Virginia Life and Health  
37 Insurance Guaranty Association Act), after October 1, 1991, §33-27-1 *et seq.* of this code  
38 (insurance holding company systems); §33-28-1 *et seq.* of this code (individual accident and  
39 sickness insurance minimum standards); §33-33-1 *et seq.* of this code (annual audited financial  
40 report); §33-34-1 *et seq.* of this code (administrative supervision); §33-34A-1 *et seq.* of this code  
41 (standards and commissioner's authority for companies considered to be in hazardous financial  
42 condition); §33-35-1 *et seq.* of this code (criminal sanctions for failure to report impairment); §33-  
43 37-1 *et seq.* of this code (managing general agents); §33-40A-1 *et seq.* of this code (risk-based  
44 capital for health organizations); and §33-41-1 *et seq.* of this code (Insurance Fraud Prevention  
45 Act) and no other provision of this chapter may apply to these corporations unless specifically  
46 made applicable by the provisions of this article. If, however, the corporation is converted into a  
47 corporation organized for a pecuniary profit or if it transacts business without having obtained a  
48 license as required by §33-24-5 of this code, it shall thereupon forfeit its right to these exemptions.

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

**§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 To the extent that coverage is provided "behavioral health, mental health, and substance  
4 use disorder" means a condition or disorder, regardless of etiology, that may be the result of a  
5 combination of genetic and environmental factors and that falls under any of the diagnostic  
6 categories listed in the mental disorders section 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: *Provided*, That any service, even if it is related to the  
12 behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall  
13 be reviewed as a medical claim and undergo all utilization review as applicable.

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

20 (c) The carrier shall:

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

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

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

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

36 (5) Establish procedures to authorize treatment with a nonparticipating provider if a  
37 covered service is not available within established time and distance standards and within a  
38 reasonable period after service is requested, and with the same coinsurance, deductible, or  
39 copayment requirements as would apply if the service were provided at, a 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 health, mental health, or substance use disorders required to  
43 be covered pursuant to this subsection that are provided by a nonparticipating provider using the  
44 same methodology that the carrier uses to reimburse covered medical services provided by  
45 nonparticipating providers and, upon request, provide evidence of the methodology to the person  
46 or provider.

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

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

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

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

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

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

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

70 (1) Data that demonstrates parity compliance for adverse determination regarding claims  
71 for behavioral health, mental health, or substance use disorder services and includes the total  
72 number 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 health, mental health, and substance use disorders and to medical and surgical  
79 benefits within each classification of benefits; and

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

83 evidentiary standards, or other factors used in applying the medical necessity criteria and each  
84 nonquantitative treatment limitation to benefits for behavioral health, mental health, and  
85 substance use disorders within each classification of benefits are comparable to, and are applied  
86 no more stringently than, the processes, strategies, evidentiary standards, or other factors used  
87 in applying the medical necessity criteria and each nonquantitative treatment limitation to medical  
88 and 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) Identifying factors used to determine whether a nonquantitative treatment limitation  
92 will 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 health, mental health, and substance use disorders  
99 are comparable to, and are applied no more stringently than, the processes and strategies used  
100 to design and apply each nonquantitative treatment limitation, as written, and the written  
101 processes and strategies used to apply each nonquantitative treatment limitation for medical and  
102 surgical benefits;

103 (D) Provide the comparative analyses, 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 health, mental health, and substance use  
106 disorders are comparable to, and are applied no more stringently than, the processes and

107 strategies used to apply each nonquantitative treatment limitation, in operation, for medical and  
108 surgical benefits; 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  
111 pursuant to this section complies with subsection (c) of this section.

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

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

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

131 the carrier is not in compliance with this section, the Insurance Commissioner may fine the carrier  
132 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.**

1 (a) Corporations organized under this article are subject to supervision and regulation of  
2 the Insurance Commissioner. The corporations organized under this article, to the same extent  
3 these provisions are applicable to insurers transacting similar kinds of insurance and not  
4 inconsistent with the provisions of this article, shall be governed by and be subject to the  
5 provisions as herein below indicated of the following articles of this chapter: §33-4-1 *et seq.* of  
6 this code (general provisions), except that §33-4-16 of this code shall not be applicable thereto;  
7 §33-6C-1 *et seq.* of this code (guaranteed loss ratio); §33-7-1 *et seq.* of this code (assets and  
8 liabilities); §33-8-1 *et seq.* of this code (investments); §33-10-1 *et seq.* of this code (rehabilitation  
9 and liquidation); §33-15-2a of this code (definitions); §33-15-2b of this code (guaranteed issue);  
10 §33-15-2d of this code (exception to guaranteed renewability); §33-15-2e of this code  
11 (discontinuation of coverage); §33-15-2f of this code (certification of creditable coverage); §33-  
12 15-2g of this code (applicability); §33-15-4e of this code (benefits for mothers and newborns);  
13 §33-15-14 of this code (individual accident and sickness insurance); §33-15-16 of this code  
14 (coverage of children); §33-15-18 of this code (equal treatment of state agency); §33-15-19 of  
15 this code (coordination of benefits with Medicaid); §33-15C-1 of this code (diabetes insurance);  
16 §33-16-3 of this code (required policy provisions); §33-16-3a of this code (mental health); §33-  
17 16-3j of this code (benefits for mothers and newborns); §33-16-3k of this code (preexisting  
18 condition exclusions); §33-16-3l of this code (guaranteed renewability); §33-16-3m of this code  
19 (creditable coverage); §33-16-3n of this code (eligibility for enrollment); §33-16-11 of this code  
20 (coverage of children); §33-16-13 of this code (equal treatment of state agency); §33-16-14 of



21 this code (coordination of benefits with Medicaid); §33-16-16 of this code (diabetes insurance);  
22 §33-16A-1 *et seq.* of this code (group health insurance conversion); §33-16C-1 *et seq.* of this  
23 code (small employer group policies); §33-16D-1 *et seq.* of this code (marketing and rate practices  
24 for small employers); §33-25F-1 *et seq.* of this code (coverage for patient cost of clinical trials);  
25 §33-26A-1 *et seq.* of this code (West Virginia Life and Health Insurance Guaranty Association  
26 Act); §33-27-1 *et seq.* of this code (insurance holding company systems); §33-33-1 *et seq.* of this  
27 code (annual audited financial report); §33-34A-1 *et seq.* of this code (standards and  
28 commissioner’s authority for companies considered to be in hazardous financial condition); §33-  
29 35-1 *et seq.* of this code (criminal sanctions for failure to report impairment); §33-37-1 *et seq.* of  
30 this code (managing general agents); §33-40A-1 *et seq.* of this code (risk-based capital for health  
31 organizations); and §33-41-1 *et seq.* of this code (privileges and immunity); and no other provision  
32 of this chapter may apply to these corporations unless specifically made applicable by the  
33 provisions of this article.

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

**§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 To the extent that coverage is provided “behavioral health, mental health, and substance  
4 use disorder” means a condition or disorder, regardless of etiology, that may be the result of a  
5 combination of genetic and environmental factors and that falls under any of the diagnostic  
6 categories listed in the mental disorders section 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: *Provided*, That any service, even if it is related to the  
12 behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall  
13 be reviewed as a medical claim and undergo all utilization review as applicable.

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

20           (c) The carrier shall:

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

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

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

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

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

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

49 (d) If the carrier offers a plan that does not cover services provided by an out-of-network  
50 provider, it may provide the benefits required in subsection (c) of this section if the services are  
51 rendered by a provider who is designated by and affiliated with the carrier only if the same  
52 requirements apply for services for a physical illness.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**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 To the extent that coverage is provided “behavioral health, mental health, and substance  
4 use disorder” means a condition or disorder, regardless of etiology, that may be the result of a  
5 combination of genetic and environmental factors and that falls under any of the diagnostic  
6 categories listed in the mental disorders section 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: *Provided*, That any service, even if it is related to the  
12 behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall  
13 be reviewed as a medical claim and undergo all utilization review as applicable.

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

20 (c) The carrier shall:

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

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

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

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

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

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



47 nonparticipating providers and, upon request, provide evidence of the methodology to the person  
48 or provider.

49 (d) If the carrier offers a plan that does not cover services provided by an out-of-network  
50 provider, it may provide the benefits required in subsection (c) of this section if the services are  
51 rendered by a provider who is designated by and affiliated with the carrier only if the same  
52 requirements apply for services for a physical illness.

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

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

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

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

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

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

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

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81 benefits within each classification of benefits; and

82 (4) The results of analyses demonstrating that, for medical necessity criteria described in  
83 subdivision (2) of this subsection and for each nonquantitative treatment limitation identified in  
84 subdivision (3) of this subsection, as written and in operation, the processes, strategies,  
85 evidentiary standards, or other factors used in applying the medical necessity criteria and each  
86 nonquantitative treatment limitation to benefits for behavioral health, mental health, and  
87 substance use disorders within each classification of benefits are comparable to, and are applied  
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92 treatment limitations shall include at a minimum:

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97 (C) Provide the comparative analyses, including the results of the analyses, performed to  
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102 to design and apply each nonquantitative treatment limitation, as written, and the written  
103 processes and strategies used to apply each nonquantitative treatment limitation for medical and  
104 surgical benefits;

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

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

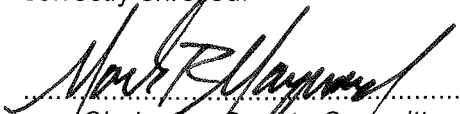
114 (h) The Insurance Commissioner shall adopt legislative rules to comply with the provisions  
115 of this section. These rules shall specify the information and analyses that carriers shall provide  
116 to the Insurance Commissioner necessary for the commissioner to complete the report described  
117 in subsection (g) of this section and shall delineate the format in which carriers shall submit such  
118 information and analyses. These rules or amendments to rules shall be proposed pursuant to the  
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122 promulgated, and any year thereafter during which the carrier makes significant changes to how  
123 it designs and applies medical management protocols.

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128 (j) The Insurance Commissioner shall enforce this section and may conduct a financial  
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133 the carrier is not in compliance with this section, the Insurance Commissioner may fine the carrier  
134 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.

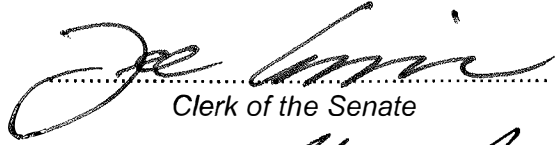
  
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Chairman, Senate Committee

  
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Chairman, House Committee


Originated in the Senate.

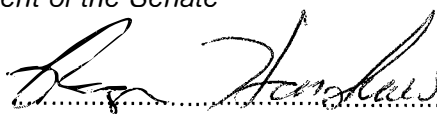
In effect 90 days from passage.

FILED  
2020 MAR 25 P 3:53  
OFFICE JESTER/REGINA  
SECRETARY OF STATE

  
.....  
Clerk of the Senate

  
.....  
Clerk of the House of Delegates

  
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President of the Senate

  
.....  
Speaker of the House of Delegates

The within is ..... approved ..... this the 25<sup>th</sup> .....  
Day of March ..... , 2020.

  
.....  
Governor

PRESENTED TO THE GOVERNOR

MAR 19 2020

Time 9:32am