WEST VIRGINIA LEGISLATURE

2021 REGULAR SESSION

Introduced

Senate Bill 583

BY SENATORS CAPUTO, BEACH, LINDSAY, RUCKER,

IHLENFELD, WOELFEL, AND UNGER

[Introduced March 5, 2021; referred

to the Committee on Banking and Insurance; and then

to the Committee on Finance]

1 A BILL to amend and reenact §5-16-7 of the Code of West Virginia, 1931, as amended; to amend
2 and reenact §5-16B-6e of said code; to amend and reenact §33-16-3v of said code; to
3 amend and reenact §33-24-7k of said code; and to amend and reenact §33-25A-8j of said
4 code, all relating to increasing the required insurance coverage for autism spectrum
5 disorders.

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
42 health benefits in the administration of its plan. With regard to both medical-surgical and mental
43 health benefits, it may make determinations of medical necessity and appropriateness and it may
44 use recognized health care quality and cost management tools including, but not limited to,
45 limitations on inpatient and outpatient benefits, utilization review, implementation of cost-
46 containment measures, preauthorization for certain treatments, setting coverage levels, setting
47 maximum number of visits within certain time periods, using capitated benefit arrangements,
48 using fee-for-service arrangements, using third-party administrators, using provider networks, and
49 using patient cost sharing in the form of copayments, deductibles, and coinsurance. Additionally,
50 the agency shall comply with the financial requirements and quantitative treatment limitations
51 specified in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation. The agency may not
52 apply any nonquantitative treatment limitations to benefits for behavioral health, mental health,
53 and 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~~
82 $90,000 per individual for three consecutive years from the date treatment commences. At the
83 conclusion of the third year, coverage for applied behavior analysis required by this subdivision
84 shall be in an amount not to exceed ~~$2,000~~ $6,000 per month, until the individual reaches 18
85 years of age, as long as the treatment is medically necessary and in accordance with a treatment
86 plan developed by a certified behavior analyst pursuant to a comprehensive evaluation or

87 reevaluation of the individual. This subdivision does not limit, replace, or affect any obligation to
88 provide services to an individual under the Individuals with Disabilities Education Act, 20 U.S.C.
89 §1400 *et seq.,* as amended from time to time, or other publicly funded programs. Nothing in this
90 subdivision requires 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.

ARTICLE 16B. WEST VIRGINIA CHILDREN'S HEALTH INSURANCE PROGRAM.

§5-16B-6e. Coverage for treatment of autism spectrum disorders.

1 (a) To the extent that the diagnosis, evaluation and treatment of autism spectrum
2 disorders are not already covered by this agency, on or after January 1, 2012, a policy, plan or
3 contract subject to this section shall provide coverage for such diagnosis, evaluation and
4 treatment, for individuals ages 18 months to 18 years. To be eligible for coverage and benefits
5 under this section, the individual must be diagnosed with autism spectrum disorder at age eight
6 or younger. Such policy shall provide coverage for treatments that are medically necessary and
7 ordered or prescribed by a licensed physician or licensed psychologist and in accordance with a
8 treatment plan developed from a comprehensive evaluation by a certified behavior analyst for an
9 individual diagnosed with autism spectrum disorder.

10 (b) The coverage shall include, but not be limited to, applied behavior analysis. Applied

behavior analysis shall be provided or supervised by a certified behavior analyst. The annual maximum benefit for applied behavior analysis required by this subsection shall be in an amount not to exceed ~~$30,000~~ $90,000 per individual, for three consecutive years from the date treatment commences. At the conclusion of the third year, coverage for applied behavior analysis required by this subsection shall be in an amount not to exceed ~~$2,000~~ $6,000 per month, until the individual reaches 18 years of age, as long as the treatment is medically necessary and in accordance with a treatment plan developed by a certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual. This section shall not be construed as limiting, replacing or affecting any obligation to provide services to an individual under the Individuals with Disabilities Education Act, 20 U.S.C. 1400 *et seq.,* as amended from time to time, or other publicly funded programs. Nothing in this section shall be construed as requiring reimbursement for services provided by public school personnel.

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

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

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

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

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

37 Finance as it may from time to time request.

38 (e) For purposes of this section, the term:

39 (1) "Applied Behavior Analysis" means the design, implementation, and evaluation of
40 environmental modifications using behavioral stimuli and consequences, to produce socially
41 significant improvement in human behavior, including the use of direct observation, measurement,
42 and functional analysis of the relationship between environment and behavior.

43 (2) "Autism spectrum disorder" means any pervasive developmental disorder, including
44 autistic disorder, Asperger's Syndrome, Rett syndrome, childhood disintegrative disorder, or
45 Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and
46 Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

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

54 (f) To the extent that the application of this section for autism spectrum disorder causes
55 an increase of at least one percent of actual total costs of coverage for the plan year the agency
56 may apply additional cost containment measures.

57 (g) To the extent that the provisions of this section require benefits that exceed the
58 essential health benefits specified under section 1302(b) of the Patient Protection and Affordable
59 Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified
60 essential health benefits shall not be required of the West Virginia Children's Health Insurance
61 Program.

CHAPTER 33. INSURANCE.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE

§33-16-3v. Required coverage for treatment of autism spectrum disorders.

1 (a) Any insurer who, on or after January 1, 2012, delivers, renews or issues a policy of
2 group accident and sickness insurance in this state under the provisions of this article shall include
3 coverage for diagnosis, evaluation and treatment of autism spectrum disorder in individuals ages
4 18 months to 18 years. To be eligible for coverage and benefits under this section, the individual
5 must be diagnosed with autism spectrum disorder at age eight or younger. Such policy shall
6 provide coverage for treatments that are medically necessary and ordered or prescribed by a
7 licensed physician or licensed psychologist and in accordance with a treatment plan developed
8 from a comprehensive evaluation by a certified behavior analyst for an individual diagnosed with
9 autism spectrum disorder.

10 (b) Coverage shall include, but not be limited to, applied behavior analysis. Applied
11 behavior analysis shall be provided or supervised by a certified behavior analyst. The annual
12 maximum benefit for applied behavior analysis required by this subsection shall be in an amount
13 not to exceed ~~$30,000~~ $90,000 per individual, for three consecutive years from the date treatment
14 commences. At the conclusion of the third year, required coverage shall be in an amount not to
15 exceed ~~$2,000~~ $6,000 per month, until the individual reaches 18 years of age, as long as the
16 treatment is medically necessary and in accordance with a treatment plan developed by a certified
17 behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual. This
18 section shall not be construed as limiting, replacing or affecting any obligation to provide services
19 to an individual under the Individuals with Disabilities Education Act, 20 U.S.C. §1400 *et seq.,* as
20 amended from time to time or other publicly funded programs. Nothing in this section shall be
21 construed as requiring reimbursement for services provided by public school personnel.

22 (c) The certified behavior analyst shall file progress reports with the insurer semiannually.

23 In order for treatment to continue, the insurer must receive objective evidence or a clinically
24 supportable statement of expectation that:

25 (1) The individual's condition is improving in response to treatment; and

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

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

29 (d) For purposes of this section, the term:

30 (1) "Applied Behavior Analysis" means the design, implementation, and evaluation of
31 environmental modifications using behavioral stimuli and consequences, to produce socially
32 significant improvement in human behavior, including the use of direct observation, measurement,
33 and functional analysis of the relationship between environment and behavior.

34 (2) "Autism spectrum disorder" means any pervasive developmental disorder, including
35 autistic disorder, Asperger's Syndrome, Rett syndrome, childhood disintegrative disorder, or
36 Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and
37 Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

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

45 (e) The provisions of this section do not apply to small employers. For purposes of this
46 section a small employer means any person, firm, corporation, partnership or association actively
47 engaged in business in the State of West Virginia who, during the preceding calendar year,
48 employed an average of no more than 25 eligible employees.

(f) To the extent that the application of this section for autism spectrum disorder causes an increase of at least one percent of actual total costs of coverage for the plan year the insurer may apply additional cost containment measures.

(g) To the extent that the provisions of this section require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of a health benefit plan when the plan is offered by a health care insurer in this state.

ARTICLE 24. HOSPITAL MEDICAL AND DENTAL CORPORATIONS.

§33-24-7k. Coverage for diagnosis and treatment of autism spectrum disorders.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article, for policies issued or renewed on or after January 1, 2012, which delivers, renews or issues a policy of group accident and sickness insurance in this state under the provisions of this article shall include coverage for diagnosis and treatment of autism spectrum disorder in individuals ages 18 months to 18 years. To be eligible for coverage and benefits under this section, the individual must be diagnosed with autism spectrum disorder at age eight or younger. The policy shall provide coverage for treatments that are medically necessary and ordered or prescribed by a licensed physician or licensed psychologist and in accordance with a treatment plan developed from a comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism spectrum disorder.

(b) Coverage shall include, but not be limited to, applied behavior analysis. Applied behavior analysis shall be provided or supervised by a certified behavior analyst. The annual maximum benefit for applied behavior analysis required by this subsection shall be in an amount not to exceed ~~$30,000~~ <u>$90,000</u> per individual, for three consecutive years from the date treatment commences. At the conclusion of the third year, coverage for applied behavior analysis required

by this subsection shall be in an amount not to exceed ~~$2,000~~ $6,000 per month, until the individual reaches 18 years of age, as long as the treatment is medically necessary and in accordance with a treatment plan developed by a certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual. This section shall not be construed as limiting, replacing or affecting any obligation to provide services to an individual under the Individuals with Disabilities Education Act, 20 U.S.C. 1400 *et seq.,* as amended from time to time or other publicly funded programs. Nothing in this section shall be construed as requiring reimbursement for services provided by public school personnel.

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

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

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

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

(d) For purposes of this section, the term:

(1) "Applied Behavior Analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

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

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

48 (e) The provisions of this section do not apply to small employers. For purposes of this
49 section a small employer means any person, firm, corporation, partnership or association actively
50 engaged in business in the state of West Virginia who, during the preceding calendar year,
51 employed an average of no more than 25 eligible employees.

52 (f) To the extent that the application of this section for autism spectrum disorder causes
53 an increase of at least one percent of actual total costs of coverage for the plan year the
54 corporation may apply additional cost containment measures.

55 (g) To the extent that the provisions of this section require benefits that exceed the
56 essential health benefits specified under section 1302(b) of the Patient Protection and Affordable
57 Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified
58 essential health benefits shall not be required of a health benefit plan when the plan is offered by
59 a corporation in this state.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8j. Coverage for diagnosis and treatment of autism spectrum disorders.

1 (a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to
2 which this article applies, any entity regulated by this article for policies issued or renewed on or
3 after January 1, 2012, which delivers, renews or issues a policy of group accident and sickness
4 insurance in this state under the provisions of this article shall include coverage for diagnosis,
5 evaluation and treatment of autism spectrum disorder in individuals ages 18 months to 18 years.
6 To be eligible for coverage and benefits under this section, the individual must be diagnosed with
7 autism spectrum disorder at age eight or younger. The policy shall provide coverage for

8 treatments that are medically necessary and ordered or prescribed by a licensed physician or
9 licensed psychologist and in accordance with a treatment plan developed from a comprehensive
10 evaluation by a certified behavior analyst for an individual diagnosed with autism spectrum
11 disorder.

12 (b) Coverage shall include, but not be limited to, applied behavior analysis. Applied
13 behavior analysis shall be provided or supervised by a certified behavior analyst. The annual
14 maximum benefit for applied behavior analysis required by this subsection shall be ~~in~~ an amount
15 not to exceed ~~$30,000~~ $90,000 per individual, for three consecutive years from the date treatment
16 commences. At the conclusion of the third year, coverage for applied behavior analysis required
17 by this subsection shall be in an amount not to exceed ~~$2,000~~ $6,000 per month, until the
18 individual reaches 18 years of age, as long as the treatment is medically necessary and in
19 accordance with a treatment plan developed by a certified behavior analyst pursuant to a
20 comprehensive evaluation or reevaluation of the individual. This section shall not be construed
21 as limiting, replacing or affecting any obligation to provide services to an individual under the
22 Individuals with Disabilities Education Act, 20 U.S.C. 1400 *et seq.,* as amended from time to time
23 or other publicly funded programs. Nothing in this section shall be construed as requiring
24 reimbursement for services provided by public school personnel.

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

28 (1) The individual's condition is improving in response to treatment; and

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

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

32 (d) For purposes of this section, the term:

33 (1) "Applied Behavior Analysis" means the design, implementation, and evaluation of

34 environmental modifications using behavioral stimuli and consequences, to produce socially
35 significant improvement in human behavior, including the use of direct observation, measurement,
36 and functional analysis of the relationship between environment and behavior.

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

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

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

48 (e) The provisions of this section do not apply to small employers. For purposes of this
49 section a small employer means any person, firm, corporation, partnership or association actively
50 engaged in business in the state of West Virginia who, during the preceding calendar year,
51 employed an average of no more than 25 eligible employees.

52 (f) To the extent that the application of this section for autism spectrum disorder causes
53 an increase of at least one percent of actual total costs of coverage for the plan year the health
54 maintenance organization may apply additional cost containment measures.

55 (g) To the extent that the provisions of this section require benefits that exceed the
56 essential health benefits specified under section 1302(b) of the Patient Protection and Affordable
57 Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified
58 essential health benefits shall not be required of a health benefit plan when the plan is offered by
59 a health maintenance organization in this state.

NOTE: The purpose of this bill is to increase the required medical coverage from various providers relating to autism spectrum disorders.

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