WEST VIRGINIA LEGISLATURE

2021 REGULAR SESSION

Introduced

House Bill 3091

FISCAL NOTE

BY DELEGATES FLEISCHAUER, ROWE, HANSEN, YOUNG,

DOYLE, GRIFFITH, LOVEJOY, GARCIA, SKAFF, AND BATES

[Introduced March 12, 2021; Referred to the

Committee on Banking and Insurance then the

Judiciary]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §33-16-3ii, relating to creating the Advance Mental Health and Addiction Parity Act; providing definitions; providing for coverage of medically necessary mental health and substance use disorder services; requiring that medical necessity determinations follow generally accepted standards; prohibiting discretionary clauses; and providing for severability.

Be it enacted by the Legislature of West Virginia:

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3ii. Advance Mental Health and Addiction Parity Act; definitions.

(a) This section is known and shall be cited as the "Advance Mental Health and Addiction Parity Act".

(b) The following definitions apply for purposes of this act:

(1) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(A) In accordance with the generally accepted standards of mental health and substance use disorder care.

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(C) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

(3) "Mental health and substance use disorders" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(4) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.

(5) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used

by an insurer to conduct utilization review.

(c) The following apply to coverage for medically necessary mental health and substance use disorder services:

(1) Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, every insurance policy issued, amended, or renewed on or after July 1, 2021, that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders.

(2) An insurer shall not limit benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute treatment at any level of care placement.

(3) All medical necessity determinations made by the insurer concerning service intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed with mental health and substance use disorders shall be conducted in accordance with the requirements of subsection (d) of this section.

(4) An insurer that authorizes a specific type of treatment by a provider pursuant to this section shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to this authorization for any reason, including, but not limited to, the insurer's subsequent rescission, cancellation, or modification of the insured's or policyholder's contract, or the insurer's subsequent determination that it did not make an accurate determination of the insured's or policyholder's eligibility. This subdivision shall not be construed to expand or alter the benefits available to the insured or policyholder under an insurance policy.

(5) If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timeliness access standards set by law or regulation, the insurer shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network

services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the insured within geographic and timely access standards. The insured shall pay no more in total for benefits rendered than the cost sharing that the insured would pay for the same covered services received from an in-network provider.

(6) An insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(7) An insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this subsection.

(8) If the commissioner determines that an insurer has violated this subsection, the commissioner may, after appropriate notice and an administrative investigation conducted under §33-2-1 *et seq.*, of this code, by order, assess a civil penalty not to exceed $5,000 for each violation, or, if a violation was willful, a civil penalty not to exceed $10,000 for each violation. The civil penalties available to the commissioner pursuant to this subsection are not exclusive and may be sought and employed in combination with any other remedies available to the commissioner under this code.

(d) Medical necessity determinations shall follow generally accepted standards, as follows:

(1) An insurer that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder

care as defined in subsection b of this section. All denials and appeals shall be reviewed by a professional with the same level of education and experience of the provider requesting the authorization.

(2) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, an insurer shall apply the level of care placement criteria and practice guidelines set forth in the most recent versions of such criteria and practice guidelines, developed by the nonprofit professional association for the relevant clinical specialty.

(3) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. For all level of care placement decisions, the insurer shall authorize placement at the level of care consistent with the insured's score using the relevant level of care placement criteria and guidelines as specified in subsection (b). If that level of placement is not available, the insurer shall authorize the next higher level of care. In the event of disagreement, the insurer shall provide full detail of its scoring using the relevant level of care placement criteria and guidelines as specified in subsection (b) to the provider of the service.

(4) To ensure the proper use of the criteria described in subsection (b), every insurer shall do all of the following:

(A) Sponsor a formal education program by nonprofit clinical specialty associations to educate the insurer's staff, including any third parties contracted with the insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(B) Make the education program available to other stakeholders, including the insurer's participating providers and covered lives.

(C) Provide, at no cost, the clinical review criteria and any training material or resources

to providers and insured patients.

(D) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(E) Conduct interrater reliability testing to ensure consistency in utilization review decision making covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in subdivisions (4) and (5) of subsection (b).

(F) Run interrater reliability reports about how the clinical guidelines are used in conjunctionwith the utilization management process and parity compliance activities.

(G) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(5) This subsection applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by an insurance policy, including prescription drugs.

(6) This subsection applies to an insurer that covers hospital, medical, or surgical expenses and conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf.

(7) If the commissioner determines that an insurer has violated this section, the commissioner may, after appropriate notice and an administrative investigation conducted under §33-2-1 *et seq.* of this code, by order, assess a civil penalty not to exceed $5,000 for each violation, or, if a violation was willful, a civil penalty not to exceed $10,000 for each violation. The civil penalties available to the commissioner pursuant to this section are not exclusive and may be sought and employed in combination with any other remedies available to the commissioner under this chapter.

(8) An insurer shall not adopt, impose, or enforce terms in its policies or provider

agreements,in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(e) Discretionary clauses prohibited.

(1) If an insurer contract offered, issued, delivered, amended, or renewed on or after July 1,2021, contains a provision that reserves discretionary authority to the insurer, or an agent of the insurer, to determine eligibility for benefits or coverage, to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

(2) For purposes of this subsection, the term “discretionary authority” means a contract provision that has the effect of conferring discretion on an insurer or other claims administrator to determine entitlement to benefits or interpret contract language that, in turn, could lead to a deferential standard of review by a reviewing court.

(3) This subsection does not prohibit an insurer from including a provision in a contract that informs an insured that, as part of its routine operations, the plan applies the terms of its contracts for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures, and processes, so long as the provision could not give rise to a deferential standard of review by a reviewing court.

(f) Severability clause. The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

NOTE: The purpose of this bill is to create the Advance Mental Health and Addiction Parity Act which would prohibit group health insurance plans from imposing treatment limitations and financial requirements on the coverage of mental health conditions that do not also apply to physical conditions. The bill includes definitions, provides for coverage of medically necessary mental health and substance use disorder services, and requires that medical necessity determinations follow generally accepted standards. The bill prohibits discretionary clauses and provides for severability.

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