WEST VIRGINIA LEGISLATURE

2023 REGULAR SESSION

Introduced

Senate Bill 219

By Senators Woodrum, Deeds, and Maynard

[Introduced January 13, 2023; referred

to the Committee on Health and Human Resources;

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; and to
2 amend said code by adding thereto a new section, designated §9-5-31; to amend said
3 code by adding thereto a new section, designated §33-15-4x; to amend said code by
4 adding thereto a new section, designated §33-16-3rr; to amend said code by adding
5 thereto a new section, designated §33-24-7x; to amend said code by adding thereto a new
6 section, designated §33-25-8u; and to amend said code by adding thereto a new section,
7 designated §33-25A-8x, all relating to requiring medically necessary care and treatment to
8 address congenital anomalies associated with cleft lip and cleft palate; setting forth
9 eligibility age; required coverage; exclusions; coverage terms; and 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 or
13 the American College of Obstetricians and Gynecologists, when performed for cancer screening
14 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 deny
22 payment for a mother or her newborn child prior to 48 hours following a vaginal delivery or prior to
23 96 hours following a caesarean section delivery if the attending physician considers discharge
24 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 45
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 in
59 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 and
63 for whom a superior result can be expected from dental care provided under general anesthesia.
64 (B) A child who is 12 years of age or younger with documented phobias or with
65 documented mental illness and with dental needs of such magnitude that treatment should not be
66 delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of
67 teeth, or other increased oral or dental morbidity and for whom a successful result cannot be
68 expected from dental care provided under local anesthesia because of such condition and for
69 whom a superior result can be expected from dental care provided under general anesthesia.
70 (8) (A) Any plan issued or renewed on or after January 1, 2012, shall include coverage for
71 diagnosis, evaluation, and treatment of autism spectrum disorder in individuals ages 18 months to
72 18 years. To be eligible for coverage and benefits under this subdivision, the individual must be
73 diagnosed with autism spectrum disorder at age eight or younger. Such plan shall provide
74 coverage for treatments that are medically necessary and ordered or prescribed by a licensed
75 physician or licensed psychologist and in accordance with a treatment plan developed from a
76 comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism
77 spectrum disorder.
78 (B) The coverage shall include, but not be limited to, applied behavior analysis which shall
79 be provided or supervised by a certified behavior analyst. The annual maximum benefit for applied
80 behavior analysis required by this subdivision shall be in an amount not to exceed $30,000 per
81 individual for three consecutive years from the date treatment commences. At the conclusion of
82 the third year, coverage for applied behavior analysis required by this subdivision shall be in an

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

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

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

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

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

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

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

106 (i) "Applied behavior analysis" means the design, implementation, and evaluation of
107 environmental modifications using behavioral stimuli and consequences in order to produce
108 socially significant improvement in human behavior and includes the use of direct observation,

109 measurement, and functional analysis of the relationship between environment and behavior.

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

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

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

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

126 (9) For plans that include maternity benefits, coverage for the same maternity benefits for
127 all individuals participating in or receiving coverage under plans that are issued or renewed on or
128 after January 1, 2014: *Provided,* That to the extent that the provisions of this subdivision require
129 benefits that exceed the essential health benefits specified under section 1302(b) of the Patient
130 Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that
131 exceed the specified essential health benefits shall not be required of a health benefit plan when
132 the plan is offered in this state.

133 (10) (A) A policy, plan, or contract that is issued or renewed on or after January 1, 2019,
134 and that is subject to this section, shall provide coverage, through the age of 20, for amino acid-

135 based formula for the treatment of severe protein-allergic conditions or impaired absorption of
136 nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the
137 gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder
138 by a physician licensed to practice in this state pursuant to either §30-3-1 *et seq.* or §30-14-1 *et*
139 *seq.* of this code:

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

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

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

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

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

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

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

155 (b) The agency shall, with full authorization, make available to each eligible employee, at
156 full cost to the employee, the opportunity to purchase optional group life and accidental death
157 insurance as established under the rules of the agency. In addition, each employee is entitled to
158 have his or her spouse and dependents, as defined by the rules of the agency, included in the
159 optional coverage, at full cost to the employee, for each eligible dependent.

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

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

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

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

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

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

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

179 (f) If the Public Employees Insurance Agency offers a plan that does not cover services
180 provided by an out-of-network provider, it may provide the benefits required in paragraph (A),
181 subdivision (6), subsection (a) of this section if the services are rendered by a provider who is
182 designated by and affiliated with the Public Employees Insurance Agency, and only if the same
183 requirements apply for services for a physical illness.

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

187 Agency notifies the covered person of the determination of the claim.

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

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

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

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

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

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

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

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

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

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

212 (4) The results of analyses demonstrating that, for medical necessity criteria described in

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

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

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

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

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

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

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

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

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

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

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

256 (l) The Plan shall provide coverage for newly born children, up to the age of 19, for the
257 medically necessary care and treatment to address congenital anomalies associated with cleft lip
258 and cleft palate to include:

259 (1) Oral and facial surgery, including reconstructive services and procedures necessary to
260 improve, restore, and maintain vital functions;

261 (2) Prosthetic treatment such as obdurators, speech appliances, and feeding appliances;

262 (3) Orthodontic treatment and management;

263 (4) Prosthodontic treatment and management;

264 (5) Otolaryngology treatment and management;

265 (6) The coverage requirements set forth in subsection do not include cosmetic surgery
266 performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve
267 appearance; and
268 (7) The Public Employees Insurance Agency may impose the same deductible,
269 coinsurance or other cost-sharing limitation that is imposed on other related surgical benefits
270 under the Plan to the benefits for cleft lip and palate set forth in this article.
271 (m) This subdivision is effective for policy, contract, plans, or agreements beginning on or
272 after July 1, 2024. This subdivision applies to all policies, contracts, plans, or agreements, subject
273 to this subsection, that are delivered, executed, issued, amended, adjusted, or renewed in this
274 state on or after the effective date of this subsection.

CHAPTER 9. HUMAN SERVICES.

ARTICLE 5. MISCELLANEOUS PROVISIONS.

§9-5-31. Required Coverage for Cleft Lip and Cleft Palate.

1 (a) Medicaid shall provide coverage for newly born children, up to the age of 19, for the
2 medically necessary care and treatment to address congenital anomalies associated with cleft lip
3 and cleft palate to include:
4 (1) Oral and facial surgery, including reconstructive services and procedures necessary to
5 improve, restore, and maintain vital functions;
6 (2) Prosthetic treatment such as obdurators, speech appliances, and feeding appliances;
7 (3) Orthodontic treatment and management;
8 (4) Prosthodontic treatment and management;
9 (5) Otolaryngology treatment and management;
10 (6) The coverage requirements set forth in this subsection do not include cosmetic surgery
11 performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve
12 appearance; and

13 (7) Medicaid may impose the same deductible, coinsurance or other cost-sharing limitation
14 that is imposed on other related surgical benefits under the Plan to the benefits for cleft lip and
15 palate set forth in this article.

16 (b) This subdivision is effective for policy, contract, plans, or agreements beginning on or
17 after July 1, 2024. This subsection applies to all policies, contracts, plans, or agreements, subject
18 to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on
19 or after the effective date of this subsection.

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4x. Required Coverage for Cleft Lip and Cleft Palate.

1 (a) The Insurer shall provide coverage for newly born children, up to the age of 19, for the
2 medically necessary care and treatment to address congenital anomalies associated with cleft lip
3 and cleft palate to include:

4 (1) Oral and facial surgery, including reconstructive services and procedures necessary to
5 improve, restore, and maintain vital functions;

6 (2) Prosthetic treatment such as obdurators, speech appliances, and feeding appliances;

7 (3) Orthodontic treatment and management;

8 (4) Prosthodontic treatment and management;

9 (5) Otolaryngology treatment and management;

10 (6) The coverage requirements set forth in this subsection do not include cosmetic surgery
11 performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve
12 appearance; and

13 (7) The Insurer may impose the same deductible, coinsurance or other cost-sharing
14 limitation that is imposed on other related surgical benefits under the Plan to the benefits for cleft
15 lip and palate set forth in this article.

16 (b) This subdivision is effective for policy, contract, plans, or agreements beginning on or
17 after July 1, 2024. This subsection applies to all policies, contracts, plans, or agreements, subject
18 to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on
19 or after the effective date of this subsection.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3rr. Required Coverage for Cleft Lip and Cleft Palate.

1 (a) The Insurer shall provide coverage for newly born children, up to the age of 19, for the
2 medically necessary care and treatment to address congenital anomalies associated with cleft lip
3 and cleft palate to include:
4 (1) Oral and facial surgery, including reconstructive services and procedures necessary to
5 improve, restore, and maintain vital functions;
6 (2) Prosthetic treatment such as obdurators, speech appliances, and feeding appliances;
7 (3) Orthodontic treatment and management;
8 (4) Prosthodontic treatment and management;
9 (5) Otolaryngology treatment and management;
10 (6) The coverage requirements set forth in this subsection do not include cosmetic surgery
11 performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve
12 appearance; and
13 (7) The Insurer may impose the same deductible, coinsurance or other cost-sharing
14 limitation that is imposed on other related surgical benefits under the Plan to the benefits for cleft
15 lip and palate set forth in this article.
16 (b) This subdivision is effective for policy, contract, plans, or agreements beginning on or
17 after July 1, 2024. This subsection applies to all policies, contracts, plans, or agreements, subject
18 to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on
19 or after the effective date of this subsection.

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

§33-24-7x. Required Coverage for Cleft Lip and Cleft Palate.

1 (a) The Insurer shall provide coverage for newly born children, up to the age of 19, for the
2 medically necessary care and treatment to address congenital anomalies associated with cleft lip
3 and cleft palate to include:
4 (1) Oral and facial surgery, including reconstructive services and procedures necessary to
5 improve, restore, and maintain vital functions;
6 (2) Prosthetic treatment such as obdurators, speech appliances, and feeding appliances;
7 (3) Orthodontic treatment and management;
8 (4) Prosthodontic treatment and management;
9 (5) Otolaryngology treatment and management;
10 (6) The coverage requirements set forth in this subsection do not include cosmetic surgery
11 performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve
12 appearance; and
13 (7) The Insurer may impose the same deductible, coinsurance or other cost-sharing
14 limitation that is imposed on other related surgical benefits under the Plan to the benefits for cleft
15 lip and palate set forth in this article.
16 (b) This subdivision is effective for policy, contract, plans, or agreements beginning on or
17 after July 1, 2024. This subsection applies to all policies, contracts, plans, or agreements, subject
18 to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on
19 or after the effective date of this subsection.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8u. Required Coverage for Cleft Lip and Cleft Palate.

1 (a) The Insurer shall provide coverage for newly born children, up to the age of 19, for the
2 medically necessary care and treatment to address congenital anomalies associated with cleft lip
3 and cleft palate to include:
4 (1) Oral and facial surgery, including reconstructive services and procedures necessary to
5 improve, restore, and maintain vital functions;
6 (2) Prosthetic treatment such as obdurators, speech appliances, and feeding appliances;
7 (3) Orthodontic treatment and management;
8 (4) Prosthodontic treatment and management;
9 (5) Otolaryngology treatment and management;
10 (6) The coverage requirements set forth in this subsection do not include cosmetic surgery
11 performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve
12 appearance; and
13 (7) The Insurer may impose the same deductible, coinsurance or other cost-sharing
14 limitation that is imposed on other related surgical benefits under the Plan to the benefits for cleft
15 lip and palate set forth in this article.
16 (b) This subdivision is effective for policy, contract, plans, or agreements beginning on or
17 after July 1, 2024. This subsection applies to all policies, contracts, plans, or agreements, subject
18 to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on
19 or after the effective date of this subsection.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8x. Required Coverage for Cleft Lip and Cleft Palate.

1 (a) The Insurer shall provide coverage for newly born children, up to the age of 19, for the
2 medically necessary care and treatment to address congenital anomalies associated with cleft lip
3 and cleft palate to include:
4 (1) Oral and facial surgery, including reconstructive services and procedures necessary to
5 improve, restore, and maintain vital functions;

6 (2) Prosthetic treatment such as obdurators, speech appliances, and feeding appliances;

7 (3) Orthodontic treatment and management;

8 (4) Prosthodontic treatment and management;

9 (5) Otolaryngology treatment and management;

10 (6) The coverage requirements set forth in this subsection do not include cosmetic surgery
11 performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve
12 appearance; and

13 (7) The Insurer may impose the same deductible, coinsurance or other cost-sharing
14 limitation that is imposed on other related surgical benefits under the Plan to the benefits for cleft
15 lip and palate set forth in this article.

16 (b) This subdivision is effective for policy, contract, plans, or agreements beginning on or
17 after July 1, 2024. This subsection applies to all policies, contracts, plans, or agreements, subject
18 to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on
19 or after the effective date of this subsection.

NOTE: The purpose of this bill is to require coverage for newly born children up to the age of 19 for medically necessary congenital anomalies of cleft lip and palate.

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