WEST VIRGINIA CODE CHAPTER 33 ARTICLE 16

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§33-16-1. Scope of article.

(a) Nothing in this article shall apply to or affect any policy of liability or workers' compensation insurance, or any policy of individual accident and sickness insurance issued in accordance with article fifteen of this chapter, or any policy issued by a fraternal benefit society.

(b) Nothing in this article shall apply to or in any way affect life insurance, endowment or annuity contracts or contracts supplemental thereto which contain no provisions relating to accident or sickness insurance except (a) such as provide additional benefits in case of death by accidental means and except (b) such as operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled as defined by the contract or supplemental contract.

(c) No accident and sickness policy or certificate shall be delivered or issued for delivery in this state insuring more than one individual (subject to the same exceptions provided for group life insurance in section one of article fourteen of this chapter) unless to one of the groups set forth in section two of this article and unless otherwise in compliance with this article.

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§33-16-1a. Definitions.

As used in this article:

(a) "Bona fide association" means an association which has been actively in existence for at least five years; has been formed and maintained in good faith for purposes other than obtaining insurance; does not condition membership in the association on any health status-related factor relating to an individual; makes accident and sickness insurance offered through the association available to all members regardless of any health status-related factor relating to members or individuals eligible for coverage through a member; does not make accident and sickness insurance coverage offered through the association available other than in connection with a member of the association; and meets any additional requirements as may be set forth in this chapter or by rule.

(b) "Commissioner" means the commissioner of insurance.

(c) "Creditable coverage" means, with respect to an individual, coverage of the individual after June 30, 1996, under any of the following, other than coverage consisting solely of excepted benefits:

(1) A group health plan;

(2) A health benefit plan;

(3) Medicare Part A or Part B, 42 U. S. C. §1395 et seq.; Medicaid, 42 U. S. C. §1396a et seq. (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act); Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), 10 U. S. C., Chapter 55; and a medical care program of the Indian Health Service or of a tribal organization;

(4) A health benefits risk pool sponsored by any state of the United States or by the District of Columbia; a health plan offered under 5 U. S. C., chapter 89; a public health plan as defined in regulations promulgated by the federal secretary of health and human services; or a health benefit plan as defined in the Peace Corps Act, 22 U. S. C. §2504(e).

(d) "Dependent" means an eligible employee's spouse or any unmarried child or stepchild under the age of twenty-five if that child or stepchild meets the definition of a "qualifying child" or a "qualifying relative" in section 152 of the Internal Revenue Code.

(e) "Eligible employee" means an employee, including an individual who either works or resides in this state, who meets all requirements for enrollment in a health benefit plan.

(f) "Excepted benefits" means:

(1) Any policy of liability insurance or contract supplemental thereto; coverage only for accident or disability income insurance or any combination thereof; automobile medical

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payment insurance; credit-only insurance; coverage for on-site medical clinics; workers' compensation insurance; or other similar insurance under which benefits for medical care are secondary or incidental to other insurance benefits; or

(2) If offered separately, a policy providing benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof, dental or vision benefits or other similar, limited benefits; or

(3) If offered as independent, noncoordinated benefits under separate policies or certificates, specified disease or illness coverage, hospital indemnity or other fixed indemnity insurance, or coverage, such as Medicare supplement insurance, supplemental to a group health plan; or

(4) A policy of accident and sickness insurance covering a period of less than one year.

(g) "Group health plan" means an employee welfare benefit plan, including a church plan or a governmental plan, all as defined in section three of the Employee Retirement Income Security Act of 1974, 29 U. S. C. §1003, to the extent that the plan provides medical care.

(h) "Health benefit plan" means benefits consisting of medical care provided directly, through insurance or reimbursement, or indirectly, including items and services paid for as medical care, under any hospital or medical expense incurred policy or certificate; hospital, medical or health service corporation contract; health maintenance organization contract; or plan provided by a multiple-employer trust or a multiple-employer welfare arrangement. "Health benefit plan" does not include excepted benefits.

(i) "Health insurer" means an entity licensed by the commissioner to transact accident and sickness in this state and subject to this chapter. "Health insurer" does not include a group health plan.

(j) "Health status-related factor" means an individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) or disability.

(k) "Medical care" means amounts paid for, or paid for insurance covering, the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, including amounts paid for transportation primarily for and essential to such care.

(l) "Mental health benefits" means benefits with respect to mental health services, as defined under the terms of a group health plan or a health benefit plan offered in connection with the group health plan.

(m) "Network plan" means a health benefit plan under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under

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contract with the health insurer.

(n) "Preexisting condition exclusion" means, with respect to a health benefit plan, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the enrollment date for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before the enrollment date.

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§33-16-1b. Applicability.

(a) The provisions of this article which generally require policies of group accident and sickness insurance to cover specific conditions or treatments, but which are not expressly made applicable to the following types of policies, do not apply to:

(1) Coverage only for accident, or disability income insurance or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' Compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for on-site medical clinics; and

(8) Other similar insurance coverage, which may be specified by rule, under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) The requirements of sections two-b, two-d, two-e and two-f, article fifteen of this chapter and the provisions of this article which generally require policies of group accident and sickness insurance to cover specific conditions or treatments, but which are not expressly made applicable to the following types of policies, do not apply to the following if provided under a separate policy, certificate, or contract of insurance:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(3) Coverage for only a specified disease or illness;

(4) Hospital indemnity or other fixed indemnity insurance;

(5) Medicare supplement insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under group accident and sickness insurance; and

(6) Any other benefits as may be specified by rule.

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§33-16-2. Eligible groups.

Any insurer licensed to transact accident and sickness insurance in this state may issue group accident and sickness policies coming within any of the following classifications:

(1) A policy issued to an employer, who shall be considered the policyholder, insuring at least two employees of the employer, for the benefit of persons other than the employer, and conforming to the following requirements:

(A) If the premium is paid by the employer the group shall comprise all employees or all of any class or classes thereof determined by conditions pertaining to the employment; or

(B) If the premium is paid by the employer and the employees jointly, or by the employees, there shall be no employee participation requirement. The term "employee" as used herein is considered to include the officers, managers and employees of the employer, the partners, if the employer is a partnership, the officers, managers and employees of subsidiary or affiliated corporations of a corporate employer, and the individual proprietors, partners and employees of individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract or otherwise. The term "employer" as used herein may include any municipal or governmental corporation, unit, agency or department and the proper officers of any unincorporated municipality or department, as well as private individuals, partnerships and corporations.

(2) A policy issued to an association or to a trust or to the trustees of a fund established, created or maintained for the benefit of members of one or more associations. The association or associations shall have at the issuance of the policy a minimum of one hundred persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least one year; and shall have a Constitution and bylaws that provide that: The association or associations hold regular meetings not less than annually to further the purposes of the members; except for credit unions, the association or associations collect dues or solicit contributions from members; and the members have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

(A) The policy may insure members of the association or associations, employees thereof or employees of members or one or more of the preceding or all of any class or classes for the benefit of persons other than the employee's employer.

(B) The premium for the policy shall be paid from:

(i) Funds contributed by the association or associations;

(ii) Funds contributed by covered employer members;

(iii) Funds contributed by both covered employer members and the association or associations;

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(iv) Funds contributed by the covered persons; or

(v) Funds contributed by both the covered persons and the association, associations or employer members.

(C) Except as provided in paragraph (D) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject coverage in writing.

(D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(E) A small employer, as defined in subdivision (r), section two, article sixteen-d of this chapter, insured under an eligible group policy provided in this subdivision shall also be subject to the marketing and rate practices provisions in article sixteen-d of this chapter.

(3) A policy issued to a bona fide association;

(4) A policy issued to a college, school or other institution of learning or to the head or principal thereof, insuring at least ten students, or students and employees, of the institution;

(5) A policy issued to or in the name of any volunteer fire department, insuring all of the members of the department or all of any class or classes thereof against any one or more of the hazards to which they are exposed by reason of the membership but in each case not less than ten members;

(6) A policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state, to insure any class or classes of individuals that could be insured under the group life policy; and

(7) A policy issued to cover any other substantially similar group which in the discretion of the commissioner may be subject to the issuance of a group accident and sickness policy or contract.

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§33-16-3. Required policy provisions.

Each such policy hereafter delivered or issued for delivery in this state shall contain in substance the following provisions:

(a) A provision that the policy, the application of the policyholder, a copy of which shall be attached to such policy, and the individual applications, if any, submitted in connection with such policy by the employees or members, shall constitute the entire contract between the parties, and that all statements made by any applicant or applicants shall be deemed representations and not warranties, and that no such statement shall void the insurance or reduce benefits thereunder unless contained in a written application.

(b) A provision that the insurer will furnish to the policyholder, for delivery to each employee or member of the insured group, an individual certificate setting forth in substance the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one certificate need be issued for each family unit.

(c) A provision that all new employees or members, as the case may be, in the groups or classes eligible for insurance, shall from time to time be added to such groups or classes eligible to obtain such insurance in accordance with the terms of the policy.

(d) No provision relative to notice or proof of loss or the time for paying benefits or the time within which suit may be brought upon the policy shall be less favorable to the insured than would be permitted in the case of an individual policy by the provisions set forth in article fifteen of this chapter.

(e) A provision that all members in groups or classes eligible for insurance provided through an employee's group plan shall be permitted to pay the premiums at the same group rate and receive the same coverages for a period not to exceed eighteen months when they are involuntarily laid off from work.

(f) Such further provisions establishing group accident and sickness minimum policy coverage standards as the commissioner shall promulgate by rule pursuant to chapter twenty-nine-a of this code.

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§33-16-3a. Same-mental health.

[Repealed.]

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§33-16-3aa. Step therapy.

(a) As used in this article:

(1) “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(2) “Health plan issuer” or “issuer” means an entity required to be licensed under this chapter that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including accident and sickness insurers, nonprofit hospital service corporations, medical service corporations and dental service organizations, prepaid limited health service organizations, health maintenance organizations, preferred provider organizations, provider sponsored network, and any pharmacy benefit manager that administers a fully-funded or self-funded plan.

(3) “Step therapy protocol” means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition, and medically appropriate for a particular patient, are covered by a health plan issuer or health benefit plan.

(4) “Step therapy override determination” means a determination as to whether a step therapy protocol should apply in a particular situation, or whether the step therapy protocol should be overridden in favor of immediate coverage of the health care provider’s selected prescription drug. This determination is based on a review of the patient’s or prescriber’s request for an override, along with supporting rationale and documentation.

(5) “Utilization review organization” means an entity that conducts utilization review, other than a health plan issuer performing utilization review for its own health benefit plan.

(b) A health benefit plan that includes prescription drug benefits, and which utilizes step therapy protocols, and which is issued for delivery, delivered, renewed, or otherwise contracted in this state on or after January 1, 2018, shall comply with the provisions of this article.

(c) Step therapy protocol exceptions include:

(1) When coverage of a prescription drug for the treatment of any medical condition is restricted for use by health plan issuer or utilization review organization through the use of a step therapy protocol, the patient and prescribing practitioner shall have access to a clear and convenient process to request a step therapy exception determination. The process shall be made easily accessible on the health plan issuer’s or utilization review organization’s website. The health plan issuer or utilization review organization must provide a prescription drug for treatment of the medical condition at least until the step therapy exception

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determination is made.

(2) A step therapy override determination request shall be expeditiously granted if:

(A) The required prescription drug is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient.

(B) The required prescription drug is expected to be ineffective based on the known relevant physical or mental characteristics of the patient and the known characteristics of the prescription drug regimen.

(C) The patient has tried the required prescription drug while under their current or a previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action and such prescription drug was discontinued due to a lack of efficacy or effectiveness, diminished effect, or an adverse event.

(D) The required prescription drug is not in the best interest of the patient, based upon medical appropriateness.

(E) The patient is stable on a prescription drug selected by their health care provider for the medical condition under consideration.

(3) Upon the granting of a step therapy override determination, the health plan issuer or utilization review organization shall authorize coverage for the prescription drug prescribed by the patient’s treating healthcare provider, provided such prescription drug is a covered prescription drug under such policy or contract.

(4) This section shall not be construed to prevent:

(A) A health plan issuer or utilization review organization from requiring a patient to try an AB-Rated generic equivalent prior to providing coverage for the equivalent branded prescription drug.

(B) A health care provider from prescribing a prescription drug that is determined to be medically appropriate.

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§33-16-3b. Home health care coverage.

(a) Any insurer who, on or after January 1, 1981, delivers or issues for delivery in this state group basic hospital expense or major medical expense coverage under this article shall make available to the policyholder home health care coverage consistent with the provisions of this section. For purposes of this section, "home health care" means health services provided by a home health agency certified in the state in which the home health services are delivered or under Title XVIII of the Social Security Act.

(b) Home health care coverage offered shall include:

(1) Services provided by a registered nurse or a licensed practical nurse;

(2) Health services provided by physical, occupational, respiratory and speech therapists;

(3) Health services provided by a home health aide to the extent that such services would be covered if provided to the insured on an inpatient basis;

(4) Medical supplies, drugs, medicines and laboratory services to the extent that they would be covered if provided to the insured on an inpatient basis; and

(5) Services provided by a licensed midwife or a licensed nurse midwife as these occupations are defined in section one, article fifteen of the code.

(c) Home health care coverage may be limited to:

(1) Services provided on the written order of a licensed physician, provided such order is renewed at least every sixty days;

(2) Services provided, directly or through contractual agreements, by a home health agency certified in the state in which the home health services are rendered or under Title XVIII of the Social Security Act; and

(3) Services as set forth in subsection (b) of this section without which the insured would have to be hospitalized.

(d) Coverage under this section shall be provided for at least one hundred home visits per insured per policy year, with each home visit by a member of a home health care team to be considered as one home health care visit including up to four hours of home health care services.

(e) No such policy need provide such coverage to persons eligible for Medicare.

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§33-16-3bb. Coverage for amino acid-based formulas.

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

(1) Immunoglobulin E and Nonimmunoglobulin E-medicated allergies to multiple food proteins;

(2) Severe food protein-induced enterocolitis syndrome;

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

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

(b) The coverage required by §33-16-3bb(a) of this code shall include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary, regardless of methodology of delivery.

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

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

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§33-16-3c. Loss ratio.

If an insurer considers a loss ratio at the time of renewal of a policy, the insurer shall, upon request of an insured, provide the loss ratio and the components of the loss ratio calculation to the insured no more than 90 days but no less than 60 days before the renewal date of the policy. For purposes of this section, “loss ratio” means the total losses paid out in medical claims divided by the total earned premiums.

Medical claims do not include dental only or vision only coverage.

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§33-16-3cc. Substance use disorder.

(a) As used in this section, the following words have the following meanings:

(1) "Concurrent review" means inpatient care is reviewed as it is provided. Medically qualified reviewers monitor appropriateness of the care, the setting, and patient progress, and, as appropriate, the discharge plans.

(2) "Covered person" means an individual, other than a Medicaid recipient, for whom coverage has been provided pursuant to the provisions of this article.

(3) "Health insurer" means the same as that term is defined in §33-16-1a of this code.

(4) "Insurance Commissioner" means the person appointed pursuant to the provisions of §33-2-1 et seq. of this code.

(5) "Physician" or "psychiatrist" means a person licensed pursuant to the provisions of either §30-3-1 et seq. or §30-14-1 et seq. of this code.

(6) "Psychologist" means a person licensed pursuant to the provisions of §30-21-1 et seq. of this code.

(7) "Substance use disorder" means the same as that term is defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and shall include substance use withdrawal.

(b) A group accident and sickness policy that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this state, or approved for issuance or renewal by the Insurance Commissioner, on or after January 1, 2019, shall provide benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities at the same level as other medical services offered by the group accident and sickness policy.

(c) The services for the treatment of substance use disorder shall be:

(1) Prescribed by a physician or psychiatrist licensed pursuant to the provisions of §30-3-1 et seq. or §30-14-1 et seq. of this code or recommended by a psychologist licensed pursuant to the provisions of §30-21-1 et seq. of this code; and

(2) Provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise state-approved facilities, as required by this code.

(d) The inpatient and outpatient treatment of substance use disorders shall be provided when determined medically necessary by the covered person's physician, psychologist, or psychiatrist. The facility shall notify the health insurer of both the admission and the initial

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treatment plan within 48 hours of the admission or initiation of treatment. If there is no in-network facility immediately available for a covered person, a group accident and sickness policy shall provide necessary exceptions to its network to ensure admission in a treatment facility within 72 hours. If a covered person is being treated at an out-of-network facility and an in-network facility becomes available during the course of the treatment plan, an insurer may transfer the covered person to the in-network facility.

(e) Providers of treatment for substance use disorders to persons covered under a covered contract shall not require prepayment of medical expenses during this 180 days in excess of applicable copayment, deductible, or coinsurance as provided in the contract.

(f) The benefits for outpatient visits may be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

(g)(1) If a health insurer determines that continued inpatient care in a facility is no longer medically necessary, the health insurer shall within 72 hours provide written notice to the covered person and the covered person's physician of its decision and the right to file for an expedited review of an adverse decision.

(2) The health insurer shall review and make a determination with respect to the internal appeal within 72 hours and communicate the determination to the covered person and the covered person's physician.

(3) If the determination is to uphold the denial, the covered person and the covered person's physician have the right to file an expedited external appeal with an independent review organization. An independent utilization review organization shall make a determination within 72 hours.

(4) If the health insurer's determination is upheld and it is determined continued inpatient care is not medically necessary, the health insurer remains responsible to provide benefits for the inpatient care through the day following the date the determination is made and the covered person is only responsible for any applicable copayment, deductible, and coinsurance for the stay through that date as applicable under the contract.

(5) The covered person shall not be discharged or released from the inpatient facility until all internal appeals and independent utilization review organization appeals are exhausted. For any costs incurred after the day following the date of determination until the day of discharge, the covered person is only responsible for any applicable cost-sharing, and any additional charges shall be paid by the facility or provider.

(h) The Insurance Commissioner shall propose rules in accordance with the provisions of §29A-3-1 et seq. of this code to develop a procedure for an expedited review of an adverse decision as set forth in this section. The Legislature finds that for the purposes of §29A-3-15 of this code, an emergency exists requiring the promulgation of an emergency rule to respond to the growing need in our state for substance abuse treatment.

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(i)(1) The benefits for the first five days of intensive outpatient or partial hospitalization services shall be provided without any retrospective review of medical necessity, and medical necessity shall be determined by the covered person's physician.

(2) The benefits beginning day six and every six days thereafter of intensive outpatient or partial hospitalization services are subject to a concurrent review of the medical necessity of the services.

(j) Medical necessity review shall use an evidence-based and peer-reviewed clinical review tool. This tool shall be developed by the Insurance Commissioner. The Insurance Commissioner shall propose rules for legislative approval in accordance with the provisions of §29A-3-1 et seq. of this code to develop the tool.

(k) The benefits for outpatient prescription drugs to treat substance use disorder shall be provided when determined medically necessary by the covered person's physician or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements.

(l) The days per plan year of benefits shall be computed based on inpatient days. One or more unused inpatient days may be exchanged for two outpatient visits. All extended outpatient services such as partial hospitalization and intensive outpatient, shall be considered inpatient days for the purpose of the visit-to-day exchange provided in this subsection.

(m) Except as provided in this section, the benefits and cost-sharing shall be provided to the same extent as for any other medical condition covered under the contract.

(n) The benefits required by this section are to be provided to all covered persons with a diagnosis of substance use disorder. The presence of additional related or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this section.

(o) The provisions of this section apply to all insurance contracts in which the health insurer has reserved the right to change the premium.

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§33-16-3d. Medicare supplement insurance.

(a) Definitions. --

(1) "Applicant" means, in the case of a group Medicare supplement policy or subscriber contract, the proposed certificate holder.

(2) "Certificate" means, for the purposes of this section, any certificate issued under a group Medicare supplement policy, which policy has been delivered or issued for delivery in this state.

(3) "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service corporations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. §1395, et seq.) or an issued policy under a demonstration project specified pursuant to amendments to the federal Social Security Act in 42 U.S.C. §1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. Such term does not include:

(A) A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations;

(B) Medicare advantage plans established under Medicare Part C, outpatient prescription drug plans established under Medicare Part D, or any health care prepayment plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

(4) "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(b) Standards for policy provisions. --

(1) The commissioner shall issue reasonable rules to establish specific standards for policy provisions of Medicare supplement policies. Such standards shall be in addition to and in accordance with the applicable laws of this state and may cover, but shall not be limited to:

(A) Terms of renewability;

(B) Initial and subsequent conditions of eligibility;

(C) Nonduplication of coverage;

(D) Probationary period;

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(E) Benefit limitations, exceptions and reductions;

(F) Elimination period;

(G) Requirements for replacement;

(H) Recurrent conditions; and

(I) Definitions of terms.

(2) The commissioner may issue reasonable rules that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair or unfairly discriminatory to any person insured or proposed for coverage under a Medicare supplement policy.

(3) Notwithstanding any other provisions of the law, a Medicare supplement policy may not deny a claim for losses incurred more than six months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(c) Minimum standards for benefits. -- The commissioner shall issue reasonable rules to establish minimum standards for benefits under Medicare supplement policies.

(d) Loss ratio standards. -- Medicare supplement policies shall be expected to return to policyholders benefits which are reasonable in relation to the premium charge. The commissioner shall issue reasonable rules to establish minimum standards for loss ratios and for Medicare supplement policies on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed to provide coverage and in accordance with accepted actuarial principles and practices. For purposes of rules issued pursuant to this subsection, Medicare supplement policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

(e) Disclosure standards. --

(1) In order to provide for full and fair disclosure in the sale of accident and sickness policies, to persons eligible for Medicare, the commissioner may require by rule that no policy of accident and sickness insurance may be issued for delivery in this state and no certificate may be delivered pursuant to such a policy unless an outline of coverage is delivered to the applicant at the time application is made.

(2) The commissioner shall prescribe the format and content of the outline of coverage required by subdivision (1) above. For purposes of this subdivision, "format" means style, arrangements and overall appearance, including such items as size, color and prominence of type and the arrangement of text and captions. Such outline of coverage shall include:

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(A) A description of the principal benefits and coverage provided in the policy;

(B) A statement of the exceptions, reductions and limitations contained in the policy;

(C) A statement of the renewal provisions including any reservation by the insurer of the right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age;

(D) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(3) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for Medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the information brochure be provided to any prospective insureds eligible for Medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

(4) The commissioner may further promulgate reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts or certificates by persons eligible for Medicare.

(f) Notice of free examination. -- Medicare supplement policies or certificates, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days from its delivery and have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner. Medicare supplement policies or certificates issued pursuant to a direct response solicitation to persons eligible for Medicare shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

(g) Administrative procedures. -- Rules promulgated pursuant to this section shall be subject to the provisions of chapter twenty-nine-a (the West Virginia Administrative Procedures Act) of this code.

(h) Severability. -- If any provision of this section or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the section and the

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application of such provision to other persons or circumstances shall not be affected thereby.

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§33-16-3dd. Prior authorization.

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

"Episode of care" means a specific medical problem, condition, or specific illness being managed including tests, procedures, and rehabilitation initially requested by the health care practitioner to be performed at the site of service, excluding out-of-network care: *Provided*, That any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

"National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the United States Department of Health and Human Services;

"Prior authorization" means obtaining advance approval from a health insurer about the coverage of a service or medication.

(b) The health insurer shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the health insurer's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

(1) Include instructions for the submission of clinical documentation;

(2) Provide an electronic notification to the health care provider confirming receipt of the prior authorization request for forms submitted electronically;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the health insurer requires a prior authorization. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list shall be updated at least quarterly to ensure that the list remains current;

(4) Inform the patient if the health insurer requires a plan member to use step therapy protocols. This shall be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the health insurer and the step therapy has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by July 1, 2024.

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(c) Provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider.

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request: *Provided*, That the health insurer shall respond to the prior authorization request within two business days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or

(2) In the opinion of a health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the health insurer shall identify all deficiencies, and within two business days from the day on the electronic receipt of the prior authorization request, return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the time the return request is received by the health care practitioner. The health insurer shall render a decision within two business days after receipt of the additional information submitted by the health care provider. If the health care provider fails to submit additional information, the prior authorization is considered denied and a new request shall be submitted.

(f) If the health insurer wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by a managed care organization is carried over to health insurers, the Public Employees Insurance Agency, and all other managed care organizations for three months if the services are provided within the state.

(h) The health insurer shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner, similar in specialty, education, and background. The health insurer's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to

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consult with the medical director after the peer-to- peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business days from the date of request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization may not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization shall be obtained.

(2) If the approval of a prior authorization requires a medication substitution, the substituted medication shall be as required under §30-5-1 *et seq*. of this code.

(k) If a health care practitioner has performed an average of 30 procedures per year and in a six-month time period during that year has received a 90 percent final prior approval rating, the health insurer may not require the health care practitioner to submit a prior authorization for at least the next six months, or longer if the insurer allows: *Provided*, That, at the end of the six-month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time period equal to the previously granted time period, or longer if the insurer allows. This exemption is subject to internal auditing by the health insurer at any time and may be rescinded if the health insurer determines the health care practitioner is not performing services or procedures in conformity with the health insurer's benefit plan, it identifies substantial variances in historical utilization, or identifies or anomalies based upon the results of the health insurer's internal audit. The insurer shall provide a health care practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit an insurer from requiring a prior authorization for an experimental treatment, non-covered benefit, pharmaceutical medication, or any out-of-network service or procedure.

(l) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, and the name of each physician whose gold card status was revoked and the reason for

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revocation.

(n) The Insurance Commissioner may assess a civil penalty for a violation of this section pursuant to §33-3-11 of this code.

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§33-16-3e. Policies to cover nursing services.

(a) Any insurer who, on or after January 1, 1984, delivers or issues a policy of group accident and sickness insurance in this state under the provisions of this article shall make available as benefits to all subscribers and members coverage for primary health care nursing services as defined in section four-b, article fifteen of this chapter, if such services are currently being reimbursed when rendered by any other duly licensed health care practitioner. No insurer may be required to pay for duplicative health care services actually provided by both a registered professional nurse or licensed midwife and other health providers.

(b) Nothing in this section may be construed to permit any registered professional nurse licensee or midwife licensee to perform professional services beyond such individual's areas of professional competence as established by education, training and experience.

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§33-16-3ee. Fairness in Cost-Sharing Calculation.

(a) As used in this section:

"Cost sharing" means any copayment, coinsurance, or deductible required by or on behalf of an insured in order to receive a specific health care item or service covered by a health plan.

"Drug" means the same as the term is defined in §30-5-4 of this code.

"Person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, nonprofit corporation, unincorporated organization, or government or governmental subdivision or agency.

"Pharmacy benefits manager" means the same as that term is defined in §33-51-3 of this code.

(b) When calculating an insured's contribution to any applicable cost sharing requirement, including, but not limited to, the annual limitation on cost sharing subject to 42 U.S.C. § 18022(c) and 42 U.S.C. § 300gg-6(b):

(1) An insurer shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person; and

(2) A pharmacy benefits manger shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person.

(c) The commissioner is authorized to propose rules for legislative approval in accordance with §29A-3-1 *et seq*. of this code, to implement the provisions of this section.

(d) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(e) If under federal law application of subsection (b) of this section would result in Health Savings Account ineligibility under Section 223 of the Internal Revenue Code, this requirement shall apply only for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code: *Provided*, That with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, the requirements of subsection (b) of this section shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

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§33-16-3f. Required policy provisions -- Treatment of temporomandibular joint disorder and craniomandibular disorder.

(a) The Legislature hereby finds that there is a need to provide guidelines regarding the coverage of temporomandibular joint disorder and craniomandibular disorder in policies issued pursuant to this article and article fifteen of this chapter, in order to provide for the health of our citizens. The purpose of this section is to require the Insurance Commissioner to develop standards regarding temporomandibular joint disorder and craniomandibular disorder and to require that all insurers writing accident and sickness policies which are covered by this article or article fifteen of this chapter, and the Public Employees Insurance Agency as set forth in article sixteen of chapter five make available this coverage to the policyholder or sponsor of each such policy. For purposes of this section, the Public Employees Insurance Agency is the policyholder.

(b) The Insurance Commissioner shall promulgate rules and regulations regarding the diagnosis and treatment for temporomandibular joint disorder and craniomandibular disorder coverage in accident and sickness policies covered by this article and article fifteen of this chapter. Such regulations shall prescribe the manner by which such coverage shall be offered to the policyholder or sponsor; that benefits shall apply whether administered by a physician or dentist, and findings regarding the projected actuarial costs of implementing said regulations.

(c) The regulations shall be developed by the Insurance Commissioner with the advice of a six-member panel to be appointed by the commissioner. Such panel shall consist of a general practicing dentist who shall be recommended by the West Virginia Dental Association, an oral and maxillofacial surgeon who shall be recommended by the West Virginia Society for Oral and Maxillofacial Dentists, a physician who shall be recommended by the West Virginia State Medical Association, a member from a Health Services Corporation who shall be recommended by the Health Services Corporation in this state, a member representing commercial health insurers who shall be recommended by the association representing accident and sickness insurance, and a representative of the Public Employees Insurance Association.

The Insurance Commissioner shall make his appointments to the panel based solely upon said recommendations thirty days after this section takes effect.

(d) This section shall only apply to policies of insurance which provide hospital, surgical or major medical expense insurance or any combination of these coverages.

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§33-16-3ff. Mental health parity.

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

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

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

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

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

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

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

(c) The carrier shall:

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

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

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

(4) Not apply any nonquantitative treatment limitations to benefits for behavioral health,

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mental health, and substance use disorders that are not applied to medical and surgical benefits within the same classification of benefits;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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treatment limitation for medical and surgical benefits;

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

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

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

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

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

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§33-16-3g. Third party reimbursement for mammography, pap smear or human papilloma virus testing.

Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, whenever reimbursement or indemnity for laboratory or X-ray services are covered, reimbursement or indemnification shall not be denied for

any of the following when performed for cancer screening or diagnostic purposes, at the direction of a person licensed to practice medicine and surgery by the board of Medicine:

(1) Mammograms when medically appropriate and consistent with the current guidelines from the United States Preventive Services Task Force.

(2) A pap smear, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists, for women age eighteen or over; and

(3) A test for the human papilloma virus (HPV)for women age eighteen or over, when medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists for women age eighteen and over.

A policy, provision, contract, plan or agreement may apply to mammograms, pap smears or human papilloma virus (HPV) test the same deductibles, coinsurance and other limitations as apply to other covered services.

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§33-16-3gg. Incorporation of the Health Benefit Plan Network Access and Adequacy Act.

The provisions of the Health Benefit Plan Network Access and Adequacy Act codified at §33-55-1 *et seq.* of this code are made applicable to the provisions of this article.

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§33-16-3h. Third party reimbursement for rehabilitation services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, 1991, provide as benefits to all subscribers and members coverage for rehabilitation services as hereinafter set forth, unless rejected by the insured.

(b) For purposes of this article and section, "rehabilitation services" includes those services which are designed to remediate patient's condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status. Rehabilitative services include by illustration and not limitation diagnostic testing, assessment, monitoring or treatment of the following conditions individually or in a combination:

(1) Stroke;

(2) Spinal cord injury;

(3) Congenital deformity;

(4) Amputation;

(5) Major multiple trauma;

(6) Fracture of femur;

(7) Brain injury;

(8) Polyarthritis, including rheumatoid arthritis;

(9) Neurological disorders, including, but not limited to, multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy and Parkinson's disease;

(10) Cardiac disorders, including, but not limited to, acute myocardial infarction, angina pectoris, coronary arterial insufficiency, angioplasty, heart transplantation, chronic arrhythmias, congestive heart failure, valvular heart disease;

(11) Burns.

(c) Rehabilitative services includes care rendered by any of the following:

(1) A hospital duly licensed by the State of West Virginia that meets the requirements for rehabilitation hospitals as described in Section 2803.2 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(2) A distinct part rehabilitation unit in a hospital duly licensed by the State of West Virginia.

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The distinct part unit must meet the requirements of Section 2803.61 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(3) A hospital duly licensed by the State of West Virginia which meets the requirements for cardiac rehabilitation as described in Section 35-25, Transmittal 41, dated August, 1989, as promulgated by the U.S. Health Care Financing Administration.

(d) Rehabilitation services do not include services for mental health, chemical dependency, vocational rehabilitation, long-term maintenance or custodial services.

(e) A policy, provision, contract, plan or agreement may apply to rehabilitation services the same deductibles, coinsurance and other limitations as apply to other covered services.

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§33-16-3hh. Incorporation of the coverage for 12-month refill for contraceptive drugs.

The provision requiring coverage for 12-month refill for contraceptive drugs codified at §33-58-1 of this code is made applicable to the provisions of this article.

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§33-16-3i. Coverage of emergency services.

(a) Notwithstanding any provision of any policy, provision, contract, plan, or agreement to which this article applies, any entity regulated by this article shall provide as benefits to all subscribers and members coverage for emergency services. A policy, provision, contract, plan, or agreement may apply to emergency services the same deductibles, coinsurance, and other limitations as apply to other covered services: *Provided*, That preauthorization or precertification shall not be required.

(b) From July 1, 1998, the following provisions apply:

(1) Every insurer shall provide coverage for emergency medical services, including prehospital services, to the extent necessary to screen and to stabilize an emergency medical condition. The insurer shall not require prior authorization of the screening services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Prior authorization of coverage shall not be required for stabilization if an emergency medical condition exists. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(2) The coverage for prehospital screening and stabilization of an emergency medical condition shall include ambulance services provided under the provisions of §16-4C-1 *et seq*. of this code, excluding air ambulance services as defined in §16-4C-3(a) of this code. The insurer shall pay claims for prehospital screening and stabilization of emergency condition by ambulance service if the insured is transported to an emergency room of a facility provider or if the patient declines to be transported against medical advice. The coverage under this section is subject to deductibles or copayment requirements of the policy, contract, or plan.

(3) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health condition made by the referring provider, the provider of the emergency services, or the covered person.

(4) Coverage of emergency services shall be subject to coinsurance, copayments, and deductibles applicable under the health benefit plan.

(5) The emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite post evaluation or post stabilization services in order to avoid material deterioration of the covered person's condition.

(6) As used in this section:

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(A) "Emergency medical services" means those services required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care;

(B) "Prudent layperson" means a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether an emergency medical condition exists for which emergency treatment should be sought;

(C) "Emergency medical condition for the prudent layperson" means one that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the person could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health, or, with respect to a pregnant woman, the health of the unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part;

(D) "Stabilize" means with respect to an emergency medical condition, to provide medical treatment of the condition necessary to assure, with reasonable medical probability, that no medical deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility: *Provided*, That this provision may not be construed to prohibit, limit, or otherwise delay the transportation required for a higher level of care than that possible at the treating facility;

(E) "Medical screening examination" means an appropriate examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists; and

(F) "Emergency medical condition" means a condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health, or, with respect to a pregnant woman, the health of the unborn child, serious impairment to bodily functions or serious dysfunction of any bodily part or organ.

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§33-16-3j. Hospital benefits for mothers and newborns.

(a) Nothing in this section shall be construed to require a mother to give birth in a hospital or to stay in the hospital for a fixed period of time following the birth of her child, but if a health benefit plan, for plan years beginning on or after January 1, 1998, provides inpatient benefits in connection with childbirth for a mother or her newborn child:

(1) The plan may not restrict benefits for any hospital stay following a normal vaginal delivery to less than forty-eight hours or following a cesarean section to less than ninety-six hours, or require a provider to obtain authorization for such length hospital stays;

(2) The plan must cover maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics or other established professional medical association; and

(3) The mother and her newborn child may be discharged prior to the expiration of the minimum length of stay required under this section only in those cases in which the decision to discharge is made by an attending provider in consultation with the mother.

(b) Benefits provided for under this section may be made subject to deductibles, coinsurance or other cost-sharing if such cost-sharing is no greater than cost-sharing for any preceding portion of the mother's or newborn child's hospital stay.

(c) Nothing in this section shall be construed to prevent a health insurer from negotiating with a provider the level and type of reimbursement for inpatient maternity or newborn care provided under a health benefit plan.

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§33-16-3k. Limitations on preexisting condition exclusions for health benefit plans.

(a) (1) For plan years beginning after June 30, 1997, a health benefit plan issued in connection with a group health plan may not impose a preexisting condition exclusion with respect to an employee or a dependent of an employee for losses incurred by the employee or dependent more than twelve months (or eighteen months for a late enrollee) after the earlier of the individual's date of enrollment in the health benefit plan or the first day of a waiting period for enrollment in the plan. Genetic information may not be treated as a condition for which a preexisting condition exclusion may be imposed absent a diagnosis of the condition related to the genetic information.

(2) A health benefit plan may impose a preexisting condition exclusion only if such condition relates to a physical or mental condition, regardless of its cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollee's enrollment date.

(3) A health benefit plan may impose no preexisting condition exclusion relating to pregnancy or in the case of a newborn covered under creditable coverage within thirty days of birth or a child adopted before the age of eighteen and covered under creditable coverage within thirty days of adoption or placement for adoption.

(b) A health maintenance organization that does not impose a preexisting condition exclusion allowed under subsection (a) of this section with respect to any particular coverage option may:

(1) Impose an affiliation period for that coverage option if the affiliation period is applied uniformly without regard to any health status-related factors and does not exceed two months (three months for a late enrollee). For purposes of this article, "affiliation period" means a period that begins on an employee's or dependent's enrollment date, runs concurrently with any waiting period under the group health plan, must expire before coverage is effective and during which the health maintenance organization need not provide medical care and may not charge any premium to the employee or dependent; or

(2) Use other alternatives approved by the commissioner to address adverse selection.

(c) Any preexisting condition exclusion period, including any waiting period or affiliation period prior to the effective date of coverage, shall be reduced by the aggregate of the periods of creditable coverage applicable to the enrollee as of the enrollment date.

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§33-16-3l. Renewability and modification of health benefit plans.

(a) A health insurer may refuse to renew a health benefit plan issued in connection with a group health plan after complying with all applicable provisions of this chapter and only for one of the following reasons:

(1) The policyholder's failure to pay premiums or the carrier's failure to receive timely premium payments;

(2) Fraud or intentional misrepresentation of material fact by the policyholder;

(3) The policyholder's failure to comply with a material plan provision relating to contribution or group participation rules;

(4) The health insurer elects to discontinue offering health benefit plans:

(A) Of a particular type, if the health insurer gives notice to each policyholder of such plan and to all covered employees or members and dependents at least ninety days before the date such coverage is discontinued: Provided, That a health insurer electing to discontinue health benefit plans to small employers shall comply with the requirements of section seven, article sixteen-d of this chapter. The health insurer shall offer each such policyholder the option to purchase any other health benefit plan offered by the health insurer to employers. In electing to discontinue health benefit plans of a particular type and in offering coverage under the preceding sentence, the health insurer shall act uniformly without regard to policyholders' claims experience or any health status-related factor relating to any covered employee, member or dependent or new employees, members or dependents who may become eligible for coverage; or

(B) Of all types, if the health insurer gives notice to the commissioner and to each policyholder and all covered employees or members and dependents at least one hundred eighty days before the date plans are discontinued: Provided, That a health insurer electing to discontinue health benefit plans to small employers shall comply with the requirements of section seven, article sixteen-d of this chapter. The health insurer shall discontinue all, and not renew any, health benefit plans issued pursuant to this article. The health insurer may not issue any health benefit plan pursuant to this article for a five-year period beginning on the date the last discontinued health benefit plan is not renewed;

(5) For a health insurer offering coverage under a network plan, the health insurer no longer has any enrollees of the network plan who live, reside or work in the plan's service area; or

(6) For health benefit plans offered only through a bona fide association, an employer ceases to be a member of the bona fide association, if coverage is terminated uniformly without respect to any health status-related factor relating to any covered employee, association member or dependent. With respect to coverage provided to an employer, a reference to "policyholder" or "plan sponsor" is deemed to include a reference to the employer.

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(b) Subject to other requirements of this chapter, a health insurer may modify a health benefit plan issued in connection with a group health plan when the health benefit plan is renewed.

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§33-16-3m. Creditable coverage.

(a)(1) A health insurer shall certify an enrollee's creditable coverage at the time an enrollee:

(A) Ceases to be covered under a health benefit plan issued in connection with a group health plan, including coverage under a COBRA continuation provision. For purposes of this article, "COBRA continuation provision" means any of the following:

(i) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines;

(ii) Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974, other than Section 609 of such act; or

(iii) Title XXII of the Public Health Service Act;

(B) Ceases to be covered under a COBRA continuation provision; and

(C) Requests certification, but no later than twenty-four months after cessation of coverage under the health benefit plan.

(2) The health insurer shall provide the enrollee a written certification of:

(A) The period of creditable coverage under the health benefit plan, including coverage, if any, under a COBRA continuation provision; and

(B) The waiting period, if any, and affiliation period, if applicable, for any coverage under the health benefit plan.

(b) For purposes of reducing an enrollee's preexisting condition exclusion period, creditable coverage shall not be counted if, after such period and before an employee's or dependent's enrollment in a health benefit plan issued in connection with a group health plan, there was a period of sixty-three days or more during all of which the individual was not covered under any creditable coverage. For purposes of this subsection, a sixty-three-day period may not include any waiting period or affiliation period prior to the effective date of an individual's coverage.

(c) For purposes of reducing an enrollee's preexisting condition exclusion period, a health insurer:

(1) Shall count a period of creditable coverage without regard to specific benefits covered during the period; or

(2) May elect to apply creditable coverage based upon each of several classes or categories of benefits in accordance with rules promulgated by the commissioner. A health insurer shall make such an election on a uniform basis for all enrollees and shall count a period of

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creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

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§33-16-3n. Eligibility for enrollment.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, a health insurer offering coverage in connection with a group health plan may not, for plan years beginning after June 30, 1997, establish rules for eligibility, including continued eligibility, of any employee or dependent to enroll under a health benefit plan based on a health status-related factor.

(b) For plan years beginning after June 30, 1997, a health benefit plan offered in connection with a group health plan shall provide that an employee or dependent of an employee who is eligible, but not enrolled, under terms of a health benefit plan may enroll under terms of the plan if the employee or dependent:

(1) Was covered under other creditable coverage when coverage was previously offered to the employee or dependent and, if required by the insurer, the employee stated in writing that the existence of other creditable coverage was the reason for declining enrollment under the health benefit plan;

(2) Lost coverage under the other creditable coverage because of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, exhaustion of COBRA continuation coverage or termination of the employer's contributions towards the other creditable coverage; and

(3) The employee requests enrollment no more than thirty days after loss of the other creditable coverage.

(c) For plan years beginning after June 30, 1997, if a health benefit plan makes coverage available to an employee's dependents, the plan shall provide that if an employee is enrolled under the plan or has met any waiting period requirement and is eligible for enrollment but for a failure to enroll during a previous enrollment period:

(1) The employee or a person who becomes a dependent of the employee through marriage, birth, adoption or placement for adoption may be enrolled under the plan, and in the case of the birth or adoption of a child, the employee's spouse who is otherwise eligible for coverage may be enrolled as a dependent, during a period of at least thirty days beginning on the later of the date dependent coverage is made available or the date of the marriage, birth, adoption or placement for adoption; and

(2) If the employee requests enrollment of a dependent during the first thirty days that dependent coverage is available, the dependent's coverage shall become effective:

(A) In the case of marriage, no later than the first day of the first month after the date the completed enrollment request is received; or

(B) In the case of a dependent's birth, adoption or placement for adoption, as of the date of birth, adoption or placement for adoption.

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§33-16-3o. Third party reimbursement for colorectal cancer examination and laboratory testing.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, reimbursement or indemnification for colorectal cancer examinations and laboratory testing may not be denied for any nonsymptomatic person fifty years of age or older, or a symptomatic person under fifty years of age, when reimbursement or indemnity for laboratory or X-ray services are covered under the policy and are performed for colorectal cancer screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery by the board of Medicine. The tests are as follows: An annual fecal occult blood test, a flexible sigmoidoscopy repeated every five years, a colonoscopy repeated every ten years and a double contrast barium enema repeated every five years.

(b) A symptomatic person is defined as: (i) An individual who experiences a change in bowel habits, rectal bleeding or stomach cramps that are persistent; or (ii) an individual who poses a higher than average risk for colorectal cancer because he or she has had colorectal cancer or polyps, inflammatory bowel disease, or an immediate family history of such conditions.

(c) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered person may apply to colorectal cancer examinations and laboratory testing.

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§33-16-3p. Required coverage for reconstruction surgery following mastectomies.

(a) Any policy of insurance described in this article which provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

(1) All stages of reconstruction of the breast on which the mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Prostheses and physical complications of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient. Coverage shall be provided for a minimum stay in the hospital of not less than forty-eight hours for a patient following a radical or modified mastectomy and not less than twenty-four hours of inpatient care following a total mastectomy or partial mastectomy with lymph node dissection for the treatment of breast cancer. Nothing in this section shall be construed as requiring inpatient coverage where inpatient coverage is not medically necessary or where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the health benefit plan policy or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

(b) A health benefit plan policy, and a health insurer providing health insurance coverage in connection with a health benefit plan policy, shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the issuer of the health benefit plan policy.

(c) A health benefit plan policy and a health insurer offering health insurance coverage in connection with a health benefit plan policy, may not:

(1) Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

(d) Nothing in this section shall be construed to prevent a health benefit plan policy or a health insurer offering health insurance coverage from negotiating the level and type of

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reimbursement with a provider for care provided in accordance with this section.

(e) The provisions of this section shall be included under any policy, contract or plan delivered after July 1, 2002.

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§33-16-3q. Required use of mail-order pharmacy prohibited.

(a) An insurer issuing group accident and sickness policies in this state pursuant to the provisions of this article may not require any person covered under a contract which provides coverage for prescription drugs to obtain the prescription drugs from a mail-order pharmacy in order to obtain benefits for the drugs.

(b) An insurer may not violate the provisions of subsection (a) of this section through the use of an agent or contractor or through the action of an administrator of prescription drug benefits.

(c) The Insurance Commissioner may propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code to implement and enforce the provisions of this section.

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§33-16-3r. Coverage for patient cost of clinical trials.

The provisions relating to clinical trials established in article twenty-five-f of this chapter shall apply to the health benefit plans regulated by this article.

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§33-16-3rr. Coverage of emergency medical services to triage and transport to alternative destination or treat in place.

(a) The following terms are defined:

(1) "911 call" means a communication indicating that an individual may need emergency medical services;

(2) "Alternative destination" means a lower-acuity facility that provides medical services, including without limitation:

(A) A federally-qualified health center;

(B) An urgent care center;

(C) A rural health clinic;

(D) A physician office or medical clinic as selected by the patient; and

(E) A behavioral or mental health care facility including, without limitation, a crisis stabilization unit.

"Alternative destination" does not include a:

(A) Critical access hospital;

(B) Dialysis center;

(C) Hospital;

(D) Private residence; or

(E) Skilled nursing facility;

(3) "Emergency medical services agency" means any agency licensed under §16-4C-6a of this code to provide emergency medical services: *Provided*, That rotary and fixed wing air ambulances are specifically excluded from the definition of an emergency medical services agency;

(4) "Medical command" means the issuing of orders by a physician from a medical facility to emergency medical services personnel for the purpose of providing appropriate patient care; and

(5) "Telehealth services" means the use of synchronous or asynchronous telecommunications technology or audio-only telephone calls by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related

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education; public health services; and health administration. The term does not include e-mail messages or facsimile transmissions.

(b) An insurer which issues or renews a health insurance policy on or after January 1, 2025, shall provide coverage for:

(1) An emergency medical services agency to:

(A) Treat an enrollee in place if the ambulance service is coordinating the care of the enrollee through telehealth services with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint;

(B) Triage or triage and transport an enrollee to an alternative destination if the ambulance service is coordinating the care of the enrollee through telehealth services with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint; or

(C) An encounter between an ambulance service and enrollee that results in no transport of the enrollee if:

(i) The enrollee declines to be transported against medical advice; and

(ii) The emergency medical services agency is coordinating the care of the enrollee through telehealth services or medical command with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint.

(c) The coverage under this section:

(1) Only includes emergency medical services transportation to the treatment location;

(2) Is subject to the initiation of response, triage, and treatment as a result of a 911 call that is documented in the records of the emergency medical services agency;

(3) Is subject to deductibles or copayment requirements of the policy, contract, or plan;

(4) Does not diminish or limit benefits otherwise allowable under a health benefit plan, even if the billing claims for medical or behavioral health services overlap in time that is billed by the ambulance service also providing care; and

(5) Does not include rotary or fixed wing air ambulance services.

(d) The reimbursement rate for an emergency medical services agency that triages, treats, and transports a patient to an alternative destination, or triages, treats, and does not transport a patient, if the patient declines to be transported against medical advice, if the ambulance service is coordinating the care of the enrollee through medical command or telemedicine with a physician for a medical-based complaint, or with a behavioral health

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specialist for a behavioral-based complaint under this section, shall be reimbursed at the same rate as if the patient were transported to an emergency room of a facility provider.

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§33-16-3s. Third-party reimbursement for kidney disease screening.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, reimbursement or indemnification for annual kidney disease screening and laboratory testing as recommended by the National Kidney Foundation may not be denied for any person when reimbursement or indemnity for laboratory or X-ray services are covered under the policy and are performed for kidney disease screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery by the board of Medicine. The tests are as follows: Any combination of blood pressure testing, urine albumin or urine protein testing and serum creatinine testing.

(b) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered person may apply to kidney disease screening and laboratory testing.

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§33-16-3t. Required coverage for dental anesthesia services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, 2009, provide as benefits to all subscribers and members coverage for dental anesthesia services as hereinafter set forth.

(b) For purposes of this article and section, "dental anesthesia services" means general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care provided to an enrollee or insured if the enrollee or insured is:

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

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

(c) Prior authorization. -- An entity subject to this section may require prior authorization for general anesthesia and associated outpatient hospital or ambulatory facility charges for dental care in the same manner that prior authorization is required for these benefits in connection with other covered medical care.

(d) An entity subject to this section may restrict coverage for general anesthesia and associated outpatient hospital or ambulatory facility charges unless the dental care is provided by:

(1) A fully accredited specialist in pediatric dentistry;

(2) A fully accredited specialist in oral and maxillofacial surgery; and

(3) A dentist to whom hospital privileges have been granted.

(e) Dental care coverage not required. -- The provisions of this section may not be construed to require coverage for the dental care for which the general anesthesia is provided.

(f) Temporal mandibular joint disorders. -- The provisions of this section do not apply to dental care rendered for temporal mandibular joint disorders.

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(g) A policy, provision, contract, plan or agreement may apply to dental anesthesia services the same deductibles, coinsurance and other limitations as apply to other covered services.

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§33-16-3u. Special enrollment period under the American Recovery and Reinvestment Act of 2009.

(a) The Legislature finds that recent attempts to assist unemployed persons during the economic downturn beginning at the end of 2008 included a federal initiative to provide subsidies to certain persons who have lost their employer-sponsored health insurance coverage. As part of the American Recovery and Reinvestment Act of 2009, certain involuntarily terminated employees and their dependents were given an second opportunity to elect subsidized COBRA coverage. This federal initiative also included relief to certain persons not covered by the federal COBRA laws, but access to such relief was made dependent on the states acting to require that such persons be given notice of their right to elect such coverage. Therefore, the Legislature intends that this section be interpreted in such a manner as to maximize the opportunity of West Virginians to obtain these much needed subsidies.

(b) Definitions. -- As used in this section:

(1) "Assistance eligible individual" means any qualified beneficiary who was eligible for continuation coverage between September 1, 2008, and February 17, 2009, due to a covered employee's termination from employment during this period and who elected such coverage.

(2) "Continuation coverage" means accident and sickness insurance coverage offered to persons pursuant to policy provisions required by subsection (e), section three of this article.

(3) "Covered employee" means a person who was involuntarily terminated by a small employer between September 1, 2008, and February 16, 2009, and at the time of his or her termination either: (i) Was eligible for but did not elect to enroll in continuation coverage; or (ii) enrolled but subsequently discontinued enrollment in continuation coverage.

(4) "Qualified beneficiary" has the same meaning as that term is defined in §607(3) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1167(3).

(5) "Small employer" means any employer that had fewer than twenty (20) employees during fifty percent (50%) or more of its typical business days in the previous calendar year.

(c) An individual who does not have an election of continuation coverage in effect on February 17, 2009, but who would be an assistance eligible individual if such election were in effect, may elect continuation coverage pursuant to this section. Such election shall be made no later than sixty days after the date the administrator of the group health plan (or other entity involved) provides the notice required by Section 3001(a)(7) of the American Recovery and Reinvestment Act of 2009. The administrator of the group health plan (or other entity involved) shall provide such individuals with additional notice of the right to elect coverage pursuant to this subsection prior to April 18, 2009.

(d) Continuation coverage elected pursuant to subsection (c) of this section shall commence

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with the first period of coverage beginning on or after February 17, 2009: Provided, That continuation coverage elected pursuant to this subsection shall not extend beyond the maximum eighteen-month period provided for by subsection (e), section three of this article.

(e) With respect to an individual who elects continuation coverage pursuant to subsection (b) of this section, the period beginning on the date of the involuntary termination and ending on the date of the first period of coverage on or after February 17, 2009, shall be disregarded for purposes of determining the sixty-three day period referred to in subsection (b), section three-m of this article.

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

(a) Any insurer who, on or after January 1, 2012, 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, evaluation and treatment of autism spectrum disorder in individuals ages eighteen months to eighteen 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. Such 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 per individual, for three consecutive years from the date treatment commences. At the conclusion of the third year, required coverage shall be in an amount not to exceed $2,000 per month, until the individual reaches eighteen 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 insurer 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.

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(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.

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

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

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§33-16-3w. Maternity coverage.

Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, any health insurance policy subject to this article, issued or renewed on or after January 1, 2014, which provides health insurance coverage for maternity services, shall provide coverage for maternity services for all persons participating in, or receiving coverage under the policy. 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 are not required of a health benefit plan when the plan is offered by a health care insurer in this state. Coverage required under this section may not be subject to exclusions or limitations which are not applied to other maternity coverage under the policy.

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§33-16-3x. Deductibles, copayments and coinsurance for anti-cancer medications.

(a) Any group accident and sickness insurance policy issued by an insurer pursuant to this article that covers anti-cancer medications that are injected or intravenously administered by a health care provider and patient administered anti-cancer medications, including, but not limited to, those medications orally administered or self-injected, may not require a less favorable basis for a copayment, deductible or coinsurance amount for patient administered anti-cancer medications than it requires for injected or intravenously administered anti-cancer medications, regardless of the formulation or benefit category determination by the policy or plan.

(b) A group accident and sickness insurance policy may not comply with subsection (a) of this section by:

(1) Increasing the copayment, deductible or coinsurance amount required for injected or intravenously administered anti-cancer medications that are covered under the policy or plan; or

(2) Reclassifying benefits with respect to anti-cancer medications.

(c) As used in this section, "anti-cancer medication" means a FDA approved medication prescribed by a treating physician who determines that the medication is medically necessary to kill or slow the growth of cancerous cells in a manner consistent with nationally accepted standards of practice.

(d) This section is effective for policy and plan years beginning on or after January 1, 2016. This section applies to all group accident and sickness insurance policies and plans subject to this article that are delivered, executed, issued, amended, adjusted or renewed in this state, on and after the effective date of this section.

(e) Notwithstanding any other provision in this section to the contrary, in the event that an insurer can demonstrate actuarially to the Insurance Commissioner that its total anticipated costs for any plan to comply with this section will exceed or have exceeded two percent of the total costs for such plan in any experience period, then the insurer may apply whatever cost containment measures may be necessary to maintain costs below two percent of the total costs for the plan: Provided, That such cost containment measures implemented are applicable only for the plan year following approval of the request to implement cost containment measures.

(f) For any enrollee that is enrolled in a catastrophic plan as defined in Section 1302(e) of the Affordable Care Act or in a plan that, but for this requirement, would be a High Deductible Health Plan as defined in section 223(c)(2)(A) of the Internal Revenue Code of 1986, and that, in connection with every enrollment, opens and maintains for each enrollee a Health Savings Account as that term is defined in section 223(d) of the Internal Revenue Code of 1986, the cost-sharing limit outlined in subsection (a) of this section shall be

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applicable only after the minimum annual deductible specified in section 223(c)(2)(A) of the Internal Revenue Code of 1986 is reached. In all other cases, this limit shall be applicable at any point in the benefit design, including before and after any applicable deductible is reached.

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§33-16-3y. Eye drop prescription refills.

An insurance policy issued by an insurer pursuant to this article for prescription topical eye medication may not deny coverage for the refilling of a prescription for topical eye medication when:

(1) The medication is to treat a chronic condition of the eye;

(2) The refill is requested by the insured prior to the last day of the prescribed dosage period and after at least 70% of the predicted days of use; and

(3) A person licensed under chapter thirty and authorized to prescribe topical eye medication indicates on the original prescription that refills are permitted and that the early refills requested by the insured do not exceed the total number of refills prescribed.

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§33-16-3z. Deductibles, copayments and coinsurance for abuse-deterrent opioid analgesic drugs.

(a) As used in this section:

(1) "Abuse-deterrent opioid analgesic drug product" means a brand name or generic opioid analgesic drug product approved by the United States Food and Drug Administration with abuse-deterrent labeling that indicates its abuse-deterrent properties are expected to deter or reduce its abuse;

(2) "Cost-sharing" means any coverage limit, copayment, coinsurance, deductible or other out-of-pocket expense requirements;

(3) "Opioid analgesic drug product" means a drug product that contains an opioid agonist and is indicated by the United States Food and Drug Administration for the treatment of pain, regardless of whether the drug product:

(A) Is in immediate release or extended release form; or

(B) Contains other drug substances.

(b) Notwithstanding any provision of any group accident and sickness insurance policy issued by an insurer pursuant to this article, on or after January 1, 2017:

(1) Coverage shall be provided for at least one abuse-deterrent opioid analgesic drug product for each active opioid analgesic ingredient;

(2) Cost-sharing for brand name abuse-deterrent opioid analgesic drug products shall not exceed the lowest tier for brand name prescription drugs on the entity's formulary for prescription drug coverage;

(3) Cost-sharing for generic abuse-deterrent opioid analgesic drug products covered pursuant to this section shall not exceed the lowest cost-sharing level applied to generic prescription drugs covered under the applicable health plan or policy; and

(4) An entity subject to this section may not require an insured or enrollee to first use an opioid analgesic drug product without abuse-deterrent labeling before providing coverage for an abuse-deterrent opioid analgesic drug product covered on the entity's formulary for prescription drug coverage.

(c) Notwithstanding subdivision (3), subsection (b) of this section, an entity subject to this section may undertake utilization review, including preauthorization, for an abuse-deterrent opioid analgesic drug product covered by the entity, if the same utilization review requirements are applied to nonabuse-deterrent opioid analgesic drug products and with the same type of drug release, immediate or extended.

WV Legislature

(d) For purposes of subsection (b) of this section, the lowest tier and the lowest cost-sharing level shall not mean the cost-sharing tier applicable to preventive care services which are required to be provided at no cost-sharing under the Patient Protection and Affordable Care Act.

WV Legislature

§33-16-3zz. Lyme disease to be covered by all health insurance policies.

Any insurer who, on or after January 1, 2019, delivers or issues a policy of group accident and sickness insurance in this state under the provisions of this article shall make available as benefits to all subscribers and members coverage on an expense-incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation shall provide coverage for long-term antibiotic therapy for a patient with Lyme disease when determined to be medically necessary and ordered by a licensed physician after making a thorough evaluation of the patient's symptoms, diagnostic test results, or response to treatment.

WV Legislature

§33-16-4. Size of type.

Every printed portion of every such policy shall be plainly printed in type of which the face shall be not smaller than ten-point, and the exceptions shall be printed with the same prominence as the benefits to which they apply.

WV Legislature

§33-16-5. Contingencies for which benefits or reimbursement of expenses permitted.

Any such policy may provide, in addition to such other indemnities, if any, as are provided in the policy on account of sickness or bodily injury or death of insured employees or members by accident, for the payment of benefits or reimbursement for expenses with respect to any one or more of the following contingencies: Hospitalization, nursing care, medical or surgical examination or treatment, or ambulance transportation, of insured employees or members, or of their spouses or children, or of dependents living with them.

WV Legislature

§33-16-6. Rider changing individual policy to group policy prohibited.

No endorsement or rider shall hereafter be used in this state to transform an individual policy issued under article fifteen of this chapter into a group policy.

WV Legislature

§33-16-7. Hospital indemnity policies not to exclude coverage for confinement in government hospital.

No policy providing hospital indemnity coverage may exclude coverage because of confinement in a hospital operated by the federal or state government.

WV Legislature

§33-16-8. Continuum of care services.

Any insurer which, on or after July 1, 1986, delivers or issues for delivery in this state any policy of group accident and sickness insurance under the provisions of this article, shall make available for purchase, at a reasonable rate, supplemental insurance coverage for continuum of care services pursuant to article five-d, chapter sixteen of this code: Provided, That any insurance carrier required to provide supplemental insurance coverage for continuum of care services hereunder shall not be required to expend funds for underwriting such supplemental coverage until the continuum of care board, in cooperation with the West Virginia state Insurance Commissioner, shall have completed a written master plan related to insurance coverage as set forth in section five, article five-d, chapter sixteen of the Code of West Virginia, 1931, as amended, including, but not limited to, the specific standards and coverages to be provided in such supplemental coverage: Provided, however, That a public hearing shall be held pursuant to the provisions of chapter twenty-nine-a of this code applicable to such proceedings prior to the considerations of the aforesaid plan by said board. The rates for continuum of care coverage shall accurately reflect the cost of such coverage and shall not be subsidized by the rate structure for any other coverage.

WV Legislature

§33-16-9. Policies not to terminate coverage because of diagnosis or treatment of acquired immune deficiency syndrome.

No insurer may cancel or nonrenew the accident and sickness insurance policy of any insured because of diagnosis or treatment of acquired immune deficiency syndrome.

WV Legislature

§33-16-10. Policies discriminating among health care providers.

Notwithstanding any other provisions of law, when any health insurance policy, health care services plan or other contract provides for the payment of medical expenses, benefits or procedures, such policy, plan or contract shall be construed to include payment to all health care providers including medical physicians, osteopathic physicians, podiatric physicians, chiropractic physicians, midwives and nurse practitioners who provide medical services, benefits or procedures which are within the scope of each respective provider's license. Any limitation or condition placed upon services, diagnoses or treatment by, or payment to any particular type of licensed provider shall apply equally to all types of licensed providers without unfair discrimination as to the usual and customary treatment procedures of any of the aforesaid providers.

WV Legislature

§33-16-11. Group policies not to exclude insured's children from coverage; required services; coordination with other insurance.

(a) An insurer issuing group accident and sickness policies in this state shall provide coverage for the child or children of each employee or member of the insured group without regard to the amount of child support ordered to be paid or actually paid by such employee or member, if any, and without regard to the fact that the employee or member may not have legal custody of the child or children or that the child or children may not be residing in the home of the employee or member.

(b) An insurer issuing group accident and sickness policies in this state shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to natural, dependent children of participants and beneficiaries, irrespective of whether the adoption has become final.

(c) An insurer shall not deny enrollment of a child under the health plan of the child's parent on the grounds that:

(1) The child was born out of wedlock;

(2) The child is not claimed as a dependent on the parent's federal tax return; or

(3) The child does not reside with the parent or in the insurer's service area.

(d) Where a child has health coverage through an insurer of a noncustodial parent the insurer shall:

(1) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(2) Permit the custodial parent, or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(3) Make payments on claims submitted in accordance with subdivision (2) of this subsection directly to the custodial parent, the provider or the state Medicaid agency: Provided, That upon payment to the custodial parent, the provider or the state Medicaid agency the insurer's obligation to the noncustodial parent under the policy with respect to the covered child's claims shall be fully satisfied.

(e) Where a parent is required by court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

(1) Permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(2) If the parent is enrolled but fails to make application to obtain coverage for the child,

WV Legislature

enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. §651 through §669, the child support enforcement program; and

(3) Not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment.

WV Legislature

§33-16-12. Child immunization services coverage.

All policies issued pursuant to this article shall cover the cost of child immunization services as described in section five, article three, chapter sixteen of this code, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration. These services shall be exempt from any deductible, per-visit charge and/or copayment provisions which may be in force in these policies or contracts. This section does not require that other health care services provided at the time of immunization be exempt from any deductible and/or copayment provisions.

WV Legislature

§33-16-13. Equal treatment of state agency.

An insurer may not impose requirements on a state agency, which has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from the insurer, that are different from requirements applicable to an agent or assignee of any other individual so covered.

WV Legislature

§33-16-14. Coordination of benefits with Medicaid.

Any health insurer, including a group health plan, as defined in 29 U.S.C. §1167, Section 607(1) of the Employee Retirement Income Security Act of 1974, health maintenance organization as defined in article twenty-five-a of this chapter or hospital and medical service corporations as defined in article twenty-four of this chapter is prohibited from considering the availability or eligibility for medical assistance in this or any other state under 42 U.S.C. §1396a, Section 1902 of the Social Security Act herein referred to as Medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders or certificateholders.

WV Legislature

§33-16-15. Individual medical savings accounts; definitions; ownership; contributions; trustees; regulations.

(a) Any insurer issuing group accident and sickness policies in this state, the Public Employees Insurance Agency and any employer offering a health benefit plan pursuant to the Employee Retirement Income Security Act of 1974, as amended, may offer a benefit plan including deductibles or copayments combined with employee self-insurance through the establishment of individual medical savings accounts. An insurer offering a benefit plan consisting of deductibles or copayments combined with employee self-insurance and individual medical savings accounts shall not be deemed to be an insurer offering individual accident and sickness insurance coverage solely because the insurer offers such a benefit plan. Notwithstanding any provision of this section, an employer may not compel an employee as a condition of employment to contribute any amount to an individual medical savings account which has been established for the employee, or to accept contributions to an individual medical savings account in lieu of other compensation or benefits. An employer may not charge an employee a fee, by any name whatsoever, in return for establishing an individual medical savings account for the employee: Provided, That a reasonable fee may be charged for any necessary services rendered in the establishment of the individual medical savings account and which fee is fully disclosed to the employee or account holder: Provided, however, That any qualified person serving as trustee of an individual medical savings account established for any employee or account holder], may impose reasonable fees, charges and expenses for administration.

An employee establishing an individual medical savings account, or for whom an account is established by an employer, may designate a percentage of the employee's contributions, if any, to that account that may be withdrawn by the employee if not needed for the payment of medical expenses: Provided, That any amount remaining in an individual medical savings account on the earlier of the date of retirement, at the age of fifty-nine and one-half years or more, of the employee or the date of death of the employee, may be withdrawn by the employee or by his or her personal representative for a purpose other than the payment of medical expenses: Provided, however, That no withdrawal pursuant to this subsection shall be subject to the additional twenty percent tax as provided in subsection (d) of this section. As used in this section, "individual medical savings account" means a trust that meets the definition of "medical savings account" set forth in paragraph (1), subsection (d), section 220 of the Internal Revenue Code of 1986, as amended, when that definition is applied without regard to sub-subparagraph (ii), subparagraph (A) of that paragraph. "Medical expenses" means expenses that fall within the definition of "qualified medical expenses" set forth in paragraph (2), subsection (d), Section 220 of the Internal Revenue Code of 1986, as amended, when that definition is applied without regard to subparagraph (C) of that paragraph.

(b) A benefit plan established pursuant to this section shall provide that medical expenses included within deductible or copayment provisions of the group accident and sickness policy and therefore not payable under the group policy for the employee or for his or her

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covered dependents be paid by the trustee, either directly or as reimbursement to an employee who has previously paid medical expenses, from the individual medical savings account. A benefit plan may limit payment of medical expenses until the group plan annual deductible is met from the medical savings account to expenses which are covered services under the group policy. Combined plans are subject to the protections afforded by article twenty-six-a of this chapter.

(c) Within one hundred eighty days of the passage of this legislation, the Tax Commissioner may promulgate emergency rules as to the keeping of records, the content and form of returns and statements, and the filing of copies of income tax returns and determination by trustees of individual medical savings accounts and by employees establishing those accounts or for whom those accounts are established: Provided, That for purposes of sections fifteen, fifteen-a and fifteen-b, article three, chapter twenty-nine-a of this code, a sufficient emergency to justify the promulgation of those rules shall be deemed to exist. The power granted by this subsection shall be in addition to the rule-making power granted to the Tax Commissioner elsewhere in this code.

(d) If any amount distributed out of an individual medical savings account is used for any purpose other than to defray medical expenses, except as specifically provided in subsection (a) of this section or except for a distribution of account assets pursuant to order of a federal bankruptcy court, the West Virginia personal income tax of the employee establishing the account or for whom the account is established, for the taxable year in which the distribution is made shall be increased by an amount equal to twenty percent of the distribution.

WV Legislature

§33-16-16. Insurance for diabetics.

[Repealed.]

WV Legislature

§33-16-17. Commissioner to propose rules.

Pursuant to chapter twenty-nine-a of this code, the commissioner shall have the power to propose rules, subject to legislative approval, necessary to implement the provisions of this article.

WV Legislature

§33-16-18. Assignment of certain benefits in dental care insurance coverage.

(a) Any entity regulated under this article that provides dental care coverage to a covered person shall honor an assignment, made in writing by the person covered under the policy, of payments due under the policy to a dentist or a dental corporation for services provided to the covered person that are covered under the policy. Upon notice of the assignment, the entity shall make payments directly to the provider of the covered services. A dentist or dental corporation with a valid assignment may bill the entity and notify the entity of the assignment. Upon request of the entity, the dentist or dental corporation shall provide a copy of the assignment to the entity.

(b) A covered person may revoke an assignment made pursuant to subsection (a) of this section with or without the consent of the provider. The revocation shall be in writing. The covered person shall provide notice of the revocation to the entity. The entity shall send a copy of the revocation notice to the dentist or dental corporation subject to the assignment. The revocation is effective when both the entity and the provider have received a copy of the revocation notice. The revocation is only effective for any charges incurred after both parties have received the revocation notice.

(c) If, under an assignment authorized in subsection (a) of this section, a dentist or dental corporation collects payment from a covered person and subsequently receives payment from the entity, the dentist or dental corporation shall reimburse the covered person, less any applicable copayments, deductibles, or coinsurance amounts, within 45 days.

(d) Nothing in this section limits an entity's ability to determine the scope of the entity's benefits, services, or any other terms of the entity's policies or to negotiate any contract with a licensed health care provider regarding reimbursement rates or any other lawful provisions.

(e) Any entity providing dental care shall provide conspicuous notice to the covered person that the assignment of benefits is optional, and that additional payments may be required if the assigned benefits are not sufficient to pay for received services.

WV Legislature

§33-16-19. Copayments for certain services.

(a) A group health plan, health benefit plan or network plan subject to this article may not impose a copayment, coinsurance, or office visit deductible amount charged to the insured for services rendered for each date of service by a licensed occupational therapist, licensed occupational therapist assistant, licensed speech-language pathologist, licensed speech-language pathologist assistant, licensed physical therapist, or a licensed physical therapist assistant that is greater than the copayment, coinsurance, or office visit deductible amount charged to the insured for the services of a primary care physician or an osteopathic physician.

(b) The group health plan, health benefit plan or network plan shall clearly state the availability of occupational therapy, speech-language therapy, and physical therapy coverage and all related limitations, conditions, and exclusions.

WV Legislature

§33-16-20. Required coverage for scalp cooling system for cancer chemotherapy treatment.

(a) For the purpose of this section, "scalp cooling system" means any device used to cool the human scalp to prevent or reduce hair loss during cancer chemotherapy treatment, provided that such device is designed and intended for repeated use and is primarily and customarily used to serve a medical purpose.

(b) Any insurer who delivers or issues a policy, plan, or contact that is issued or renewed on or after January 1, 2027, under the provisions of this article and provides coverage for cancer chemotherapy treatment shall provide coverage for scalp cooling systems used in connection with cancer chemotherapy treatment as defined by the Centers for Medicare and Medicaid Services. Coverage provided under this section may be subject to annual deductibles and coinsurance, including copayments, as may be deemed appropriate by the commissioner and as are consistent with those established for other benefits within a given policy.

WV Legislature

§33-16-21. Prohibiting surprise billing of ground emergency medical services by non-participating providers.

For a health insurance policy issued by an insurer on or after January 1, 2027:

(1) Payment by an insurer to a non-participating emergency medical services agency for covered ambulance services provided under the provisions of §16-4C-1 *et seq*. of this code, excluding air ambulance services as defined in §16-4C-3(a) of this code, to a covered enrollee in accordance with subdivision (2) of this section:

Shall be considered payment in full for the ambulance services provided, except for any copayment, coinsurance, deductible, and other cost-sharing amounts that the insurer requires the covered enrollee to pay.

(2) The insurer shall provide direct payment to a non-participating emergency medical services agency for covered ground ambulance services provided to a covered individual:

(A) At the rate of 200 percent of the current published rate for ambulance services as established by the Centers for Medicare and Medicaid Services under Title XVIII of the federal Social Security Act, 42 U.S.C. 1395 *et seq*., for the same ambulance services provided in the same geographic area; or

(B) According to the non-participating emergency medical service agency's billed charges, whichever is less.

(3) The copayment, coinsurance, deductible, and other cost-sharing amounts that an insurer requires a covered individual to pay in connection with ground ambulance services provided to the covered individual by a non-participating emergency medical services agency shall not exceed the copayment, coinsurance, deductible, and other cost-sharing amounts that the covered individual would be required to pay if the ambulance services had been provided to the covered individual by a participating emergency medical services agency.

(4) If an insurer receives a clean claim for ground ambulance services provided to a covered individual by a non-participating emergency medical services agency, the insurer shall remit payment for the ambulance services directly to the non-participating emergency medical services agency not more than 30 days after receiving a clean claim and shall not send payment to the covered individual.

(5) An insurer shall either pay or deny a clean claim for ground ambulance services provided to a covered individual by a non-participating emergency medical services agency within 30 days of receipt of the claim, except in the following circumstances:

(A) Another payor or party is responsible for the claim;

(B) The insurer is coordinating benefits with another payor;

WV Legislature

(C) The provider has already been paid for the claim;

(D) The claim was submitted fraudulently; or

(E) There was a material misrepresentation in the claim.

(6) If an insurer denies a claim for ground ambulance services provided to a covered individual by a non-participating emergency medical services agency, the insurer shall provide written notice that:

(A) Acknowledges the date of the receipt of the claim; and

(B) States that the insurer is declining to pay all or part of the claim and sets forth the specific reason or reasons for declining to pay the claim in full; or

(C) States that additional information is needed to determine whether all or part of the claim is payable and specifically describes the additional information that is needed.

WV Legislature