WEST VIRGINIA CODE CHAPTER 33 ARTICLE 24

§33-24-1. Declaration of policy.

In view of the desirability of making available to the people of this state increased hospital, medical, dental services and other health services, the declared policy of the Legislature in the enactment of this article is to encourage the organization, promotion and expansion of hospital service corporations, medical service corporations, dental service corporations and health service corporations by exempting them from the payment of all taxes and from the operation of the general insurance laws of this state, but at the same time subjecting them to such regulation as may be necessary for the adequate protection of those members of the public who subscribe for the services offered by such corporation.

§33-24-2. Definitions.

For the purpose of this article:

(a) "Corporation" means either a hospital service corporation, a medical service corporation, a dental service corporation or a health service corporation.

(b) "Hospital service corporation" means a nonprofit, nonstock corporation, organized in accordance with the provisions of article one, chapter thirty-one of this code, for the sole purpose of contracting with the public and with hospitals and other health agencies for hospital or other health services to be furnished to subscribers under terms of their contract with the corporation, and controlled by a board of directors, not more than twenty percent of whom, or whose spouse, parent, child, brother or sister by blood or marriage, are engaged in the providing of health care and at least eighty percent of whom shall be chosen as representatives of the interests of consumers, elderly persons, organized labor and business subscribers.

(c) "Hospital service" means only such hospital or other health care, to be provided by hospitals or other health agencies, or such payment therefor, as may be specified in the contract made by the subscriber with the corporation.

(d) "Medical service corporation" means a nonprofit, nonstock corporation, organized in accordance with the provisions of article one, chapter thirty-one of this code, for the sole purpose of contracting with the public and with duly licensed physicians, duly licensed dentists and duly licensed podiatrists for medical or surgical services and with duly licensed chiropractors and other health agencies for other health services to be furnished to subscribers under terms of their contract with the corporation, and controlled by a board of directors, not more than twenty percent of whom, or whose spouse, parent, child, brother or sister by blood or marriage, are engaged in the providing of health care and at least eighty percent of whom shall be chosen as representatives of the interests of consumers, elderly persons, organized labor and business subscribers.

(e) "Medical service" means only such medical, surgical, or other health care, to be provided by duly licensed physicians, duly licensed dentists, duly licensed podiatrists or other health agencies and only such health care, to be provided by duly licensed chiropractors, or such payment therefor, as may be specified in the contract made by the subscribed with the corporation.

(f) "Dental service corporation" means a nonprofit, nonstock corporation, organized in accordance with the provisions of article one, chapter thirty-one of this code, for the sole purpose of contracting with the public and with duly licensed dentists for dental services to be furnished to subscribers under terms of their contracts with the corporations, and controlled by a board of directors, not more than twenty percent of whom or whose spouse, parent, child, brother or sister by blood or marriage, are engaged in the providing of health care and at least eighty percent of whom shall be chosen as representatives of the interests

of consumers, elderly persons, organized labor and business subscribers.

(g) "Dental service" means only such dental care, to be provided by duly licensed dentists, duly licensed physicians, or such payment therefor, as may be specified in the contract made by the subscriber with the corporation.

(h) "Health service corporation" means a nonprofit, nonstock corporation, organized in accordance with the provisions of article one, chapter thirty-one of this code, for the purpose of contracting with the public and with hospitals and other health agencies for hospital or other health services to be furnished to subscribers or for the purpose of contracting with the public and with duly licensed physicians, duly licensed dentists and duly licensed chiropodists-podiatrists for medical or surgical services and with duly licensed chiropractors and other health agencies for other health services or for the purpose of contracting with the public and with duly licensed dentists for dental services to be furnished to subscribers, all under terms of their contract or contracts with the corporation, and controlled by a board of directors, not more than twenty percent of whom, or whose spouse, parent, child, brother or sister by blood or marriage, are engaged in the providing of health care and at least eighty percent of whom shall be chosen as representatives of the interests of consumers, elderly persons, organized labor and business subscribers. A hospital service corporation, or hospital service corporations, a medical service corporation, or medical service corporations, or a dental service corporation, or dental service corporations, licensed in accordance with the provisions of this article shall be authorized and permitted to merge into or consolidate with other such corporations in accordance with the merger or consolidation provisions of sections one hundred fifty and one hundred fifty-one, article one, chapter thirty-one of the code, to form a health service corporation: Provided, That no such merger or consolidation shall be effectuated unless in advance thereof the plan, agreement and other supporting documents have been filed with and approved in writing by the commissioner. The commissioner shall give such approval within a reasonable time after such filing unless he finds such plan or agreement:

(1) Is contrary to law; or

(2) Hazardous to the interests of the subscribers of any corporations involved; or

(3) Would substantially reduce the security of and service to be rendered to the subscribers of any corporation involved.

If the commissioner does not approve any such plan or agreement he shall so notify the corporation or corporations in writing specifying his reasons therefor.

(i) "Health service" means such hospital, medical, surgical, dental care or other health care to be provided by hospitals or other health agencies, duly licensed physicians, duly licensed dentists, duly licensed podiatrists or other health care, to be provided by duly licensed chiropractors, as the case may be, or such payment therefor, as may be specified in the contract made by the subscriber with the corporation.

(j) "Service" means such hospital, medical, dental and other health service as shall be provided under the terms of the contracts issued by the corporation to subscribers.

(k) "Commissioner" means the Insurance Commissioner of West Virginia.

§33-24-3. Corporations affected by article; eligibility of hospitals, physicians, dentists, chiropodists-podiatrists and chiropractors.

(a) Every such corporation operating within this state shall be subject to the provisions of this article.

(b) Every hospital or other health agency in this state meeting the standards prescribed by the board of directors of each such corporation shall be eligible for participation in any hospital service plan, or health service plan, operating in this state. Every duly licensed physician, duly licensed dentist, duly licensed chiropodist-podiatrist, duly licensed chiropractor or other health agency in this state meeting the standards prescribed by the board of directors of each such corporation shall be eligible for participation in any medical service plan, or health service plan, operating in this state. Every duly licensed dentist or duly licensed physician in this state meeting the standards prescribed by the board of directors of each such corporation shall be eligible for participation in any dental service plan, or health service plan, operating in this state. The board of directors of every such corporation may also prescribe standards for hospitals, physicians, dentists, chiropodists-podiatrists, chiropractors and other health agencies located in states adjoining this state, and all such hospitals, physicians, dentists, chiropodists-podiatrists, chiropractors and other health agencies meeting such standards shall be eligible for participation in such plans.

§33-24-4. Exemptions; applicability of insurance laws.

(a) Every corporation defined in §33-24-2 of this code is hereby declared to be a scientific, nonprofit institution and exempt from the payment of all property and other taxes. Every corporation, to the same extent the provisions are applicable to insurers transacting similar kinds of insurance and not inconsistent with the provisions of this article, shall be governed by and be subject to the provisions as herein below indicated, of the following articles of this chapter: §33-2-1 *et seq.* of this code (Insurance Commissioner); §33-4-1 *et seq.* of this code (general provisions), except that §33-4-16 of this code may not be applicable thereto; §33-5-20 of this code (borrowing by insurers); §33-6-34 of this code (fee for form, rate and rule filing); §33-6C-1 *et seq.* of this code (guaranteed loss ratios as applied to individual sickness and accident insurance policies); §33-7-1 *et seq.* of this code (assets and liabilities); §33-8A-1 *et seq.* of this code (use of clearing corporations and Federal Reserve book-entry system); §33-11-1 *et seq.* of this code (unfair trade practices); §33-12-1 *et seq.* of this code (insurance producers and solicitors), except that the agent's license fee shall be $25; §33-15-2a of this code (definitions); §33-15-2b of this code (guaranteed issue; limitation of coverage; election; denial of coverage; network plans); §33-15-2d of this code (exceptions to guaranteed renewability); §33-15-2e of this code (discontinuation of particular type of coverage; uniform termination of all coverage; uniform modification of coverage); §33-15-2f of this code (certification of creditable coverage); §33-15-2g (applicability); §33-15-4e of this code (benefits for mothers and newborns); §33-15-14 of this code (policies discriminating among health care providers); §33-15-16 of this code (policies not to exclude insured's children from coverage; required services; coordination with other insurance); §33-15-18 of this code (equal treatment of state agency); §33-15-19 of this code (coordination of benefits with Medicaid); §33-15A-1 *et seq.* of this code (West Virginia Long-Term Care Insurance Act); §33-15C-1 *et seq.* of this code (diabetes insurance); §33-16-3 of this code (required policy provisions); §33-16-3a of this code (same - mental health); §33-16-3d of this code (Medicare supplement insurance); §33-16-3f of this code (required policy provisions - treatment of temporomandibular joint disorder and craniomandibular disorder); §33-16-3j of this code (hospital benefits for mothers and newborns); §33-16-3k of this code (limitations on preexisting condition exclusions for health benefit plans); §33-16-3l of this code (renewability and modification of health benefit plans); §33-16-3m of this code (creditable coverage); §33-16-3n of this code (eligibility for enrollment); §33-16-11 of this code (group policies not to exclude insured's children from coverage; required services; coordination with other insurance); §33-16-13 of this code (equal treatment of state agency); §33-16-14 of this code (coordination of benefits with Medicaid); §33-16-16 of this code (insurance for diabetics); §33-16A-1 *et seq.* of this code (group health insurance conversion); §33-16C-1 *et seq.* of this code (employer group accident and sickness insurance policies); §33-16D-1 *et seq.* of this code (marketing and rate practices for small employer accident and sickness insurance policies); §33-26A-1 *et seq.* of this code (West Virginia Life and Health Insurance Guaranty Association Act), after October 1, 1991, §33-27-1 *et seq.* of this code (insurance holding company systems); §33-28-1 *et seq.* of this code (individual accident and sickness insurance minimum standards); §33-33-1 *et seq.* of this code (annual audited financial report); §33-34-1 *et seq.* of this code (administrative supervision); §33-34A-1 *et seq.* of this code (standards

and commissioner's authority for companies considered to be in hazardous financial condition); §33-35-1 *et seq.* of this code (criminal sanctions for failure to report impairment); §33-37-1 *et seq.* of this code (managing general agents); §33-40A-1 *et seq.* of this code (risk-based capital for health organizations); and §33-41-1 *et seq.* of this code (Insurance Fraud Prevention Act) and no other provision of this chapter may apply to these corporations unless specifically made applicable by the provisions of this article. If, however, the corporation is converted into a corporation organized for a pecuniary profit or if it transacts business without having obtained a license as required by §33-24-5 of this code, it shall thereupon forfeit its right to these exemptions.

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

§33-24-4a. 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 insurance regulated by this article.

§33-24-4b. Applicability of insurance fraud prevention act.

Notwithstanding any provision of this code to the contrary, article forty-one of this chapter is applicable to hospital service corporations, medical service corporations, dental service corporations and health service corporations.

§33-24-5. Licenses; name of corporation.

(a) No such corporation shall enter into any contract with a subscriber until it has obtained from the commissioner a license as provided in this section. Application for a license shall be made on forms to be prescribed and furnished by the commissioner.

(b) The application shall be accompanied by a copy of the following documents: (1) Certificate of incorporation; (2) bylaws; (3) contracts between the corporation and participating hospitals, physicians, dentists or other health agencies; (4) proposed contracts to be issued to subscribers, setting forth the hospital, medical or dental service to which subscribers are entitled, and the table of rates to be charged for such service; and (5) financial statement showing the amount of contributions paid, or agreed to be paid, to the corporation for working capital, the name or names of each contributor and the terms of each contribution.

(c) The commissioner shall, upon payment to him of a license fee of $200, issue a license authorizing the corporation to transact business in this state in the area to be served by it, if he is satisfied (1) that the applicant is incorporated in this state under the provisions of article one, chapter thirty-one of this code, as a bona fide nonprofit corporation, (2) that the contracts between the corporation and participating hospitals, physicians, dentists and other health agencies contain all the terms required by section seven of this article, (3) that the working capital available to the corporation will be sufficient to pay all operating expenses, other than payment for hospital, medical or dental services, for a reasonable period after the issuance of the license, and (4) that the proposed plan will serve the best interests of all of the people of the area in which the corporation intends to operate, regardless of their race, color or economic status. Any license so issued may be renewed annually upon payment to the commissioner of a renewal fee of $200.

(d) The term of such license, renewal, refusal to license, revocation, suspension or penalty in lieu thereof shall be governed by the provisions of sections eight, nine, ten and eleven, article three of this chapter, in the same manner that these sections are applicable to insurers generally.

(e) No such corporation shall include in its name the words "insurance," "casualty," "surety," "health and accident," "accident and sickness," "mutual," or any other words descriptive of the insurance business; nor shall its name be so similar to that of any insurer which was licensed to transact insurance in this state when such corporation was formed, as to tend, in the opinion of the commissioner, to confuse the public.

§33-24-6. Commissioner to enforce article; approval of contracts, forms, rates and fees.

(a) It shall be the duty of the commissioner to enforce the provisions of this article. If the commissioner finds that a corporation is impaired, he may issue such orders and otherwise require that the corporation take all actions that in his judgment are necessary for the corporation to cure the impairment. Failure of the corporation to follow such orders and directions is evidence that the management is incompetent and grounds for an order of rehabilitation or liquidation, as the commissioner deems appropriate.

(b) No such corporation shall deliver or issue for delivery any subscriber's contract, changes in the terms of such contract, application, rider or endorsement, until a copy thereof and the rates pertaining thereto have been filed with and approved by the commissioner. All such forms filed with the commissioner shall be deemed approved after the expiration of sixty days from the date of such filing unless the commissioner shall have disapproved the same, stating his reasons for such disapproval in writing. Such forms may be used prior to the expiration of such periods if written approval thereof has been received from the commissioner.

(c) No rates to be charged subscribers shall be used or established by any such corporation unless and until the same have been filed with the commissioner and approved by him The procedure for such filing and approval shall be the same as that prescribed in subsection (b) of this section for the approval of forms. The commissioner shall approve all such rates which are not excessive, inadequate or unfairly discriminatory.

(d) The commissioner shall pass upon the actuarial soundness of the schedule of fees to be paid hospitals, physicians, dentists and other health agencies.

§33-24-6a. Loss ratio.

If a corporation utilizes a group's loss ratio as a rating factor at the time of renewal of a policy, plan, or contract, the corporation shall, upon request of an insured or subscriber, provide the loss ratio and the components of the loss ratio calculation to the insured or subscriber no more than 90 days but no less than 60 days before the renewal date of the policy, plan, or contract. For purposes of this section, "loss ratio" means the total losses paid out in medical claims divided by the total earned premiums: *Provided*, That that the requirements of this section do not apply to a dental service corporation as that term is defined in this article.

§33-24-7. Required provisions in contracts made by corporations with hospitals, physicians, dentists and other health agencies.

Each contract made by the corporation with participating hospitals, physicians, dentists and other health agencies shall contain the following provisions:

(a) That the hospital, physician, dentist or other health agency will render to any subscriber such service as he may be entitled to under the terms and conditions of the contract issued to the subscriber by the corporation.

(b) That in submitting bills to the corporation for services rendered to subscribers under the terms of their contracts, the hospitals, physicians, dentists and other health agencies will make only such charges as are set forth in an agreed schedule of fees to be paid by the corporation.

§33-24-7a. Contracts to cover nursing service.

(a) Any contract made under the provisions of this article shall, on or after January 1, 1984, contain a provision that the corporation shall make available as covered 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 corporation 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 scope of professional competence as established by education, training and experience.

§33-24-7b. Third party reimbursement for mammography, pap smear or human papilloma virus testing.

(a) 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 either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists, for women age eighteen or over; or

(3) A test for the human papilloma virus (HPV), 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 or over.

(b) 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.

§33-24-7c. 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.

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.

§33-24-7d. Required provisions in contracts which include child immunization services in the terms of the contract.

Each contract made by the corporation with participating hospitals, physicians, and other health agencies which provide immunizations to children shall require that bills submitted to the corporation for child immunization services rendered under the terms of their contracts will set forth separately those charges for said services. Charges for other health care services provided during the same visit shall not be included in the charge for immunization services.

§33-24-7e. 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:

(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.

§33-24-7f. 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.

§33-24-7g. 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

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.

§33-24-7h. Required use of mail-order pharmacy prohibited.

(a) A corporation defined in section two 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) A corporation 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.

§33-24-7i. 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.

§33-24-7j. 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.

(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.

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

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

(b) Coverage shall include, but not be limited to, applied behavior analysis. Applied behavior analysis shall be provided or supervised by a certified behavior analyst. The annual maximum benefit for applied behavior analysis required by this subsection shall be in an amount not to exceed $30,000 per individual, for three consecutive years from the date treatment commences. At the conclusion of the third year, coverage for applied behavior analysis required by this subsection shall be in an amount not to exceed $2,000 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 agency semiannually. In order for treatment to continue, the insurer must receive objective evidence or a clinically supportable statement of expectation that:

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

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

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

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

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

behavior.

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

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

(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 corporation 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 corporation in this state.

§33-24-7l. Maternity coverage.

Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, a 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.

§33-24-7m. Deductibles, copayments and coinsurance for anti-cancer medications.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any group accident and sickness insurance policy, plan, contract or agreement issued by an entity regulated by 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) An accident or sickness insurance policy, plan, contract or agreement 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 entity subject to this article can demonstrate actuarially to the Insurance Commissioner that its total anticipated costs for any policy, plan, contract or agreement to comply with this section will exceed or have exceeded two percent of the total costs for such policy, plan, contract or agreement in any experience period, then the entity may apply whatever cost containment measures may be necessary to maintain costs below two percent of the total costs for the policy, plan, contract or agreement: Provided, That such cost containment measures implemented are applicable only for the plan year or experience period 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 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.

§33-24-7n. Eye drop prescription refills.

A contract, plan or agreement 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.

§33-24-7o. 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 policy, provision, contract, plan or agreement to which this article applies, 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.

(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.

§33-24-7p. 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

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.

§33-24-7q. 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 §33-24-7q(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.

§33-24-7r. 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) "Insurance Commissioner" means the person appointed pursuant to the provisions of §33-2-1 of this code.

(4) "Health benefit plan" means the same as that term is defined in §33-24-7p of this code.

(5) "Health plan issuer" means the same as that term is defined in §33-24-7p of this code.

(6) "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.

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

(8) "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 health benefit plan offered by a health plan issuer 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 health benefit plan.

(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 insurer of both the admission and the initial 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 health benefit plan offered by a health plan issuer shall provide necessary exceptions to its network to ensure admission in a treatment facility within 72 hours. A health benefit plan may transfer a covered person to an in-network facility if one becomes available during the course of the treatment plan. 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 an insurer determines that continued inpatient care in a facility is no longer medically necessary, the 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 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 insurer's determination is upheld and it is determined continued inpatient care is not medically necessary, the 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.

(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 insurer has reserved the right to change the premium.

§33-24-7s. 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.

(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 day 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 health insurer is carried over to all other managed care organizations, health insurers, and the Public Employees Insurance Agency 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

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 the 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, this 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, at any time, by the health insurer 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 other 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, the name of each physician whose gold card status was revoked and the reason for

revocation.

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

§33-24-7t. 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.

§33-24-7u. 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 health, 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,

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;

(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.

(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 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 offered pursuant to 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.

§33-24-7v. 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 is made applicable to the provisions of this article.

§33-24-7w. 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.

§33-24-7x. Copayments for certain services.

(a) A policy, provision, contract, plan, or agreement subject to this article may not impose a copayment, coinsurance, or office visit deductible amount charged to a subscriber 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 subscriber for the services of a primary care physician or an osteopathic physician.

(b) The policy, provision, contract, plan, or agreement shall clearly state the availability of occupational therapy, speech-language therapy, and physical therapy coverage and all related limitations, conditions, and exclusions.

§33-24-7y. 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

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

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.

§33-24-8. Contract or certificate to be furnished to policyholders and subscribers; payment for health care rendered needy persons.

(a) Every such corporation shall deliver to each contract holder a copy of the contract and to each holder of a master group contract for delivery to each subscriber to such group contract a certificate setting forth the essential terms of the contract to be performed.

(b) A corporation may accept from governmental agencies payment of all or part of the cost of subscriptions for hospital, medical or other health care rendered needy persons, and may accept from private agencies, corporations, associations, groups or individuals, similar payment for such service to be rendered needy or other persons.

§33-24-9. Payroll deduction for governmental employees.

The officer charged with the duty of preparing the payroll of any subscriber, who is an employee of the state government or of any of its political subdivisions, including state-operated educational institutions, may upon request of the subscriber deduct from his payroll the amount of the fee owed by the subscriber to any hospital service corporation or medical service corporation, provided enrollment regulations of the particular corporation are satisfied, in which case the officer shall pay over such amount to the corporation.

§33-24-10. Investments; bonds of corporate officers and employees, minimum statutory surplus.

(a) The funds of any corporation shall be invested only as follows:

(1) The first $2 million of the funds shall be in cash or government securities of the type described in paragraph (A) or (B), subdivision (1), subsection (a), section eleven, article eight of this chapter or paragraph (A), (B) or (C), subdivision (3) of said subsection.

(2) The balance of the funds may be in cash, invested in the classes of investments described in subdivision (1), subsection (a), section eleven, article eight of this chapter or invested in the classes of investments described in the following sections of article eight of this chapter: Subdivision (4), subsection (a) and section eleven (preferred stock), section twelve (investment pools), section thirteen (equity interests), section fourteen (tangible personal property under lease), section fifteen (mortgage loans and real estate), section sixteen (securities lending, repurchase, reverse repurchase and dollar roll transactions), section seventeen (foreign investments) and section eighteen (derivative transactions). All investments are subject to all the restrictions and conditions contained in said article eight as applying to similar investments of insurers generally.

(b) Every officer or employee of any corporation, who is entrusted with the handling of its funds, shall furnish, in an amount fixed by the board of directors of the corporation, with the approval of the commissioner, a bond with corporate surety, conditioned upon the faithful performance of all his or her duties.

(c) A corporation shall have and maintain statutory surplus funds of at least $2 million: Provided, That any corporation duly licensed under this article in West Virginia prior to the effective date of this section whose surplus requirements are increased by virtue of this section shall maintain statutory surplus funds of at least $500,000 after the effective date of this section, and any corporation is then subject to the full $2 million statutory surplus requirement.

§33-24-11. Reciprocity with other service plans; payment authorized.

Hospital, medical, dental and health service corporations licensed and operating under provisions of this article are hereby authorized to promote and encourage reciprocity with other licensed hospitals, medical, dental and health plans, both within and without the state, in expanding their services to subscribers. In the event that a subscriber to a plan requires emergency hospital, medical, dental or health service, or, in the event that the particular services that he receives are not available through the plan to which he subscribes, such plan is hereby authorized to make payment on behalf of such subscribed for such service on a basis not to exceed its schedule of fees to be paid hospitals, physicians or dentists previously approved by the commissioner and on file in his office.

§33-24-12. Creation of subsidiary corporation or corporations.

In addition to the other rights given a corporation under the provisions of this article, a health service corporation may, subject to prior approval of the commissioner, create a subsidiary corporation or corporations, either nonprofit corporation or a corporation organized for pecuniary profit, for any lawful business purpose which is related to and promotes the purposes for which hospital, medical, dental and health service corporations are organized: Provided, That no subsidiary corporation created pursuant to the provisions of this section shall be entitled to the exemptions established by the provisions of this article and all such subsidiary corporations shall be governed by and subject to all other applicable provisions of this code: Provided, however, That no such subsidiary corporation shall be entitled to the exemptions provided under section seven of this article.

§33-24-13. Continuum of care services.

Any hospital service corporation, medical service corporation or health service corporation which, on or after July 1, 1986, delivers or issues for delivery in this state any subscriber contract 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.

§33-24-14. Delinquency proceedings.

From and after July 1, 2004, any delinquency proceeding commenced against a corporation subject to this article for the purpose of liquidating, rehabilitating, reorganizing or conserving the corporation shall be considered to be a delinquency proceeding against an insurance company and shall be undertaken pursuant to the provisions of article ten of this chapter. Any delinquency proceeding pending against a corporation subject to this article prior to July 1, 2004, will be administered and concluded under the law in effect at the time the delinquency proceeding was commenced.

§33-24-15. 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.

§33-24-16.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-17.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-18.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-19.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-21.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-22.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-23.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-24.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-25.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-26.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-27.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-28.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-29.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-30.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-31.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-32.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-33.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-34.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-35.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-36.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-37.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-38.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-39.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-40.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-41.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-42.

Repealed.

Acts, 2004 Reg. Sess., Ch. 143.

§33-24-43. 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.

§33-24-44. Authority of commissioner to promulgate rules and regulations regarding affiliate and subsidiary operating results.

The commissioner may as he deems necessary after notice and hearing promulgate rules and regulations in accordance with chapter twenty-nine-a of this code to define the commissioner's authority to consider the operating results of an insurer's affiliates and subsidiaries in the rate making and solvency determination of that insurer.

§33-24-45. 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.

§33-24-46. 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;

(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.