WEST VIRGINIA CODE: §33-25-8J

§33-25-8j. Deductibles, copayments and coinsurance for anti-cancer medications.

(a) Notwithstanding any provision of any policy, contract, plan or agreement to which this article applies, a policy, contract, plan or agreement issued to a member or subscriber 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) A contract issued to a member or subscriber that is subject to this article 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, contract, or plan or agreement; 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, plan or agreement years beginning on or after January 1, 2016. This section applies to all policies, plans, contracts or agreements 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 benefits to all members or subscribers to comply with this section will exceed or have exceeded two percent of the total costs for all benefits of the 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.