WEST VIRGINIA CODE CHAPTER 33 ARTICLE 25

WV Legislature

§33-25-1. Declaration of policy.

In view of the desirability of making available to the people of this state various methods of procuring and financing increased hospital, medical, dental, other health services, or any one or more of them, the declared policy of the Legislature in the enactment of this article is to encourage the organization, promotion and expansion of health care 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 corporations.

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§33-25-2. Definitions.

For the purpose of this article, unless the context otherwise indicates:

(a) "Health care corporation" or "corporation" shall mean a corporation organized and licensed under the provisions of this article.

(b) "Direct health care services" shall, subject to the limitations contained in this article, include all such services as are designed to preserve or restore a person's health.

(c) "Subscriber" shall mean a person (including, as the case may be, the members of his family) who subscribes to the direct health care plan of a corporation.

(d) "Commissioner" means the Insurance Commissioner of the State of West Virginia.

(e) "Statutory surplus" means the minimum amount of unencumbered surplus which an association or corporation must maintain pursuant to the requirements of this article.

(f) "Surplus" means the amount by which an association's or corporation's assets exceeds its liabilities and required reserves based upon the financial information which would be required by this chapter for the preparation of the association's or corporation's annual statement.

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§33-25-3. Incorporation; purposes; name; limitations.

Any law to the contrary notwithstanding, nonprofit, nonstock corporations may be organized in accordance with the provisions of article one, chapter thirty-one of the Code of West Virginia, for the sole purpose of providing any or all of the following direct health care services, at the expense of the corporation, to its members and subscribers through contracts with duly licensed physicians and surgeons, osteopathic physicians and surgeons, chiropractors, chiropodists, nurses, dentists, optometrists and pharmacists, and any others who are licensed to engage in the practice of the healing arts, as well as hospitals, clinics, convalescent centers, nursing homes, and any other persons, corporations, associations, and institutions engaged in the business of providing facilities, appliances, supplies and services incidental to such health care.

No such corporation shall include in its name the words "insurance," "casualty," "surety," "health and accident," "accident and sickness," "mutual," or any other words, which in the opinion of the commissioner are descriptive of the insurance, casualty or surety business, or deceptively similar to the name or description of any insurance or surety corporation doing business in the state.

A corporation shall provide only direct health care services to the subscribers to its health care plan and shall not provide for the payment of any cash or cash indemnity to or on behalf of a subscriber: Provided, That a corporation may provide a cash reimbursement to a subscriber who employs or obtains in the event of an emergency the health care services of any person, corporation, association or institution named or referred to in this section and located outside the territorial boundaries within which the corporation is licensed to operate.

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§33-25-4. Board of directors.

The board of directors of any corporation organized under this article shall consist of at least seven members, all of whom shall be residents of the State of West Virginia, a majority of whom shall be subscribers to its services, one of whom shall be a person licensed to practice medicine under the laws of the State of West Virginia, one of whom shall be a person connected with the healing arts, and one of whom shall be a member of the general public not connected with any contracting party. The members of the board shall serve without compensation but may be reimbursed for expenses incurred in carrying out their duties as members of the board.

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§33-25-5. Exemption from taxes.

Every such corporation is hereby declared to be a charitable, scientific, nonprofit institution and as such exempt from the payment of all property and other taxes.

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§33-25-6. Supervision and regulation by Insurance Commissioner; exemption from insurance laws.

(a) Corporations organized under this article are subject to supervision and regulation of the Insurance Commissioner. The corporations organized under this article, to the same extent these 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: §33-4-1 *et seq.* of this code (general provisions), except that §33-4-16 of this code shall not be applicable thereto; §33-6C-1 *et seq.* of this code (guaranteed loss ratio); §33-7-1 *et seq.* of this code (assets and liabilities); §33-8-1 *et seq.* of this code (investments); §33-10-1 *et seq.* of this code (rehabilitation and liquidation); §33-15-2a of this code (definitions); §33-15-2b of this code (guaranteed issue); §33-15-2d of this code (exception to guaranteed renewability); §33-15-2e of this code (discontinuation of coverage); §33-15-2f of this code (certification of creditable coverage); §33-15-2g of this code (applicability); §33-15-4e of this code (benefits for mothers and newborns); §33-15-14 of this code (individual accident and sickness insurance); §33-15-16 of this code (coverage of children); §33-15-18 of this code (equal treatment of state agency); §33-15-19 of this code (coordination of benefits with Medicaid); §33-15C-1 of this code (diabetes insurance); §33-16-3 of this code (required policy provisions); §33-16-3a of this code (mental health); §33-16-3j of this code (benefits for mothers and newborns); §33-16-3k of this code (preexisting condition exclusions); §33-16-3l of this code (guaranteed renewability); §33-16-3m of this code (creditable coverage); §33-16-3n of this code (eligibility for enrollment); §33-16-11 of this code (coverage of children); §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 (diabetes insurance); §33-16A-1 *et seq.* of this code (group health insurance conversion); §33-16C-1 *et seq.* of this code (small employer group policies); §33-16D-1 *et seq.* of this code (marketing and rate practices for small employers); §33-25F-1 *et seq.* of this code (coverage for patient cost of clinical trials); §33-26A-1 *et seq.* of this code (West Virginia Life and Health Insurance Guaranty Association Act); §33-27-1 *et seq.* of this code (insurance holding company systems); §33-33-1 *et seq.* of this code (annual audited financial report); §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 (privileges and immunity); and no other provision of this chapter may apply to these corporations unless specifically made applicable by the provisions of this article.

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

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§33-25-6a. Applicability of insurance fraud prevention act.

Notwithstanding any provision of this code to the contrary, article forty-one of this chapter is applicable to health care corporations.

WV Legislature

§33-25-7. Licenses.

(a) Before it may issue any contract to a subscriber, a corporation desiring to establish, maintain and operate a direct health care plan must first obtain from the commissioner a license as provided in this section.

(b) Applications for an original license shall be made on forms prescribed and furnished by the commissioner and shall be accompanied by the following documents and information: (1) Certificate of incorporation; (2) bylaws; (3) list of names and residence addresses of all officers and board of directors of the corporation; (4) contracts between the corporation and persons, firms, corporations or associations to render direct health care services; (5) proposed contracts to be issued to subscribers setting forth in detail the direct health care services to which subscribers are entitled and the table of rates to be charged for such services; (6) financial statement showing the assets and liabilities of the corporation, the amount of contributions paid, or agreed to be paid, to the corporation for working capital, the names or name of each contributor and the terms of each contribution; and (7) any additional information as the commissioner may require.

(c) Within thirty days after receipt of an application, 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 the Code of West Virginia as a bona fide, nonprofit corporation, (2) that the health care plan which the corporation proposes to operate, as well as the forms of all contracts which it proposes to issue under such health care plan, are based upon sound business principles and will be in every respect equitable, just and fair to the subscriber, (3) that the working capital available to the corporation will be sufficient to pay all operating expenses during the subscription period, (4) that the proposed plan will adequately serve the best interests of all the people of the area in which the corporation intends to operate, regardless of their race, color or religion, and (5) that the corporation shall have and maintain statutory surplus funds of at least $2,000,000: Provided, That corporations 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 have until January 1, 1994, to meet such increased requirements.

(d) The commissioner may refuse to license a corporation when he determines that such corporation has not complied with the laws of this state, or that it is not in the best interest of the people of the state that such corporation be licensed, or that such corporation would transact business in this state in an improper, illegal or unjust manner. In such event, the commissioner shall enter an order refusing such license and the applicant therefor may have a hearing and judicial review in accordance with the applicable provisions of article two of this chapter relating to hearings before and judicial review of orders entered by the commissioner.

(e) All licenses issued under the provisions of this article shall expire at midnight on the

thirty-first day of March next following the date of issuance. The commissioner shall renew annually the license of all corporations which qualify and make applications therefor upon a form prescribed by the commissioner upon payment to the commissioner of a renewal fee of $200.

(f) The commissioner shall, after notice and hearing, refuse to renew or shall revoke or suspend the license of a corporation, if the corporation: (1) Violates any provision of this article; (2) fails to comply with any lawful rule, regulation or order of the commissioner; (3) is transacting its business in an illegal, improper or unjust manner, or is operating in contravention of its articles of incorporation or any amendments thereto, of its bylaws, or of its health care plan; (4) is found by the commissioner to be in an unsound condition or in such condition as to jeopardize its obligations to subscribers and those with whom it has contracted; (5) compels subscribers to its health care program to accept less than the obligation due them under their contracts or agreements with the corporation; (6) refuses to be examined or to produce its accounts, records and files for examination by the commissioner when required; (7) fails to pay any final judgment rendered against it in West Virginia within thirty days after the judgment became final or time for appeal expired, whichever is later; (8) fails to pay when due to the State of West Virginia any fees, charges or penalties required by this chapter.

In those cases where the commissioner has the right to revoke, suspend or terminate the license or any renewal thereof of said corporation, the commissioner shall, by order, require the corporation to pay to the State of West Virginia a penalty in the sum not exceeding $1,000, and on the failure of the corporation to pay the penalty within thirty days after notice thereof, the commissioner shall revoke or suspend the license of the corporation.

When any license has been revoked, suspended or terminated, the commissioner may reinstate the license when he is satisfied that the conditions causing the revocation, suspension or termination have ceased to exist and are unlikely to recur.

In the event the commissioner revokes, suspends or terminates a license, the corporation may demand a hearing in the manner provided in article two of this chapter.

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§33-25-8. Commissioner to enforce article; approval of contracts, forms and rates; reserve fund; membership fee.

(a) It shall be the duty of the commissioner to enforce the provisions of this article.

(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 thirty days from the date of such filing unless the commissioner shall have disapproved the same, stating his reasons for such disapproval in writing, except that such period may be extended for an additional period not to exceed fifteen days upon written notice thereof from the commissioner to the applicant. 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 all direct health care services plans.

(e) The corporation shall accumulate a fund to be derived from a minimum of two percent of every subscriber's monthly premium which shall be known as a contingency and liability reserve fund except that the same shall not exceed an amount equal to three months' average obligation of said corporation, nor shall it fall below a minimum of one month's average obligation of said corporation. Said fund shall be expended by the corporation according to rules and regulations to be promulgated by the commissioner.

In addition to the above requirements, every subscriber shall pay into the corporation a membership fee equal to one monthly premium. The membership fee shall be collected in full by said corporation within ninety days of said subscriber's application for membership.

(f) Each such rate filing and each such form filing made with the commissioner pursuant to this section is subject to the filing fee of section thirty-four, article six of this chapter.

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§33-25-8a. Third party reimbursement for mammography or 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; and

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

(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.

WV Legislature

§33-25-8b. 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 no limited to, acute myocardial infarction, angina pectoris, coronary arterial insufficiency, angioplasty, heart transplantation, chronic arrhythmias, congestive heart failure, valvular heart disease;

(11) Burns.

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

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

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

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

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

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

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

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§33-25-8c. Third party payment for child immunization services.

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, 1994, provide as benefits to all subscribers and members coverage for child immunization services as described in section five, article three, chapter sixteen of this code. This coverage will cover all costs associated with immunization, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration. These services shall be exempt from any deductible, per-visit charge and/or copayment provisions which may be in force in these policies, provisions, plans, agreements or contracts. This section does not require that other health care services provided at the time of immunization be exempt from any deductible and/or copayment provisions.

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§33-25-8d. Coverage of emergency services.

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

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

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

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

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

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

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

(6) As used in this section:

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

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

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

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

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

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

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§33-25-8e. Third party reimbursement for colorectal cancer examination and laboratory testing.

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

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

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

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§33-25-8f. Required use of mail-order pharmacy prohibited.

(a) A health care corporation issuing a contract under the provisions of this article may not require any person covered under a contract which provides coverage for prescription drugs to obtain the prescription drugs from a mail-order pharmacy in order to obtain benefits for the drugs.

(b) A health care 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.

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§33-25-8g. Third-party reimbursement for kidney disease screening.

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

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

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§33-25-8h. 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

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the same deductibles, coinsurance and other limitations as apply to other covered services.

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§33-25-8i. 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.

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§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

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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.

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§33-25-8k. 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.

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§33-25-8l. 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.

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

WV Legislature

§33-25-8m. Step therapy.

(a) As used in this article:

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

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

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

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

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

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

(c) Step therapy protocol exceptions include:

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

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determination is made.

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

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

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

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

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

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

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

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

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

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

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§33-25-8n. 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 §33-25-8n(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.

WV Legislature

§33-25-8o. 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 §33-25-8m of this code.

(5) “Health plan issuer” means the same as that term is defined in §33-25-8m of this code.

(6) “Physician” or “psychiatrist” means a person licensed pursuant to the provisions of either §30-3-1 et seq. or §30-3-14 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 offered by a health plan issuer.

(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.

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(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. 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 that 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

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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 is 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.

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§33-25-8p. 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. These forms shall be placed in an easily identifiable and accessible place on the health insurer's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

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

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

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

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

(5) Be prepared by July 1, 2024.

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

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

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

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

(e) If the information submitted is considered incomplete, the health insurer shall identify all deficiencies, and within two business days from the day on the electronic receipt of the prior authorization request, return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the 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

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consult with the medical director after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business days from the date of 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, the renewal shall be granted for a time period equal to the previously granted time period, or longer is 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 variance in historical utilization, or 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

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revocation.

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

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§33-25-8q. Fairness in Cost-Sharing Calculation.

(a) As used in this section:

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

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

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

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

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

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

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

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

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

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

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§33-25-8r. 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,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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treatment limitation for medical and surgical benefits;

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

(E) Disclose the specific findings and conclusions reached by the Insurance Commissioner that the results of the analyses indicate that each health benefit plan 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.

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§33-25-8s. Incorporation of the Health Benefit Plan Network Access and Adequacy Act.

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

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§33-25-8t. Incorporation of the coverage for 12-month refill for contraceptive drugs.

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

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§33-25-8u. 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 or member 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 or member 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.

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§33-25-8v. Coverage of emergency medical services to triage and transport to alternative destination or treat in place.

(a) The following terms are defined:

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

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

(A) A federally-qualified health center;

(B) An urgent care center;

(C) A rural health clinic;

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

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

"Alternative destination" does not include a:

(A) Critical access hospital;

(B) Dialysis center;

(C) Hospital;

(D) Private residence; or

(E) Skilled nursing facility;

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

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

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

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

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

(1) An emergency medical services agency to:

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

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

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

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

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

(c) The coverage under this section:

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

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

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

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

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

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

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

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§33-25-9. Annual report.

Every corporation shall annually on or before March 1, file, with its application for renewal license, a report, verified by an officer of the corporation, with the commissioner, showing its condition on the last day of the preceding calendar year, on forms required by section fourteen, article four of this chapter, which report shall include:

(a) A financial statement of such corporation, including its balance sheet and its receipts and disbursements for the preceding calendar year;

(b) A list of the names and residence addresses of all its officers and directors, and the total amount of expense reimbursement to all officers and directors during the preceding calendar year;

(c) The number of subscribers' contracts issued by such corporation and outstanding;

(d) The names of those persons (other than subscribers), corporations, associations, and institutions with which such corporation has agreements;

(e) Number and type of services currently covered under the health care plan of the corporation.

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§33-25-10. Examination of corporation; report of examination; objections to report; access to books, records, etc.; removal of records, etc., from state.

(a) The commissioner or his or her accredited examiners may at any reasonable time and shall, at least once every five years, visit each health care corporation and thoroughly examine its financial condition and methods of doing business and ascertain whether it has complied with all of the laws and rules of this state. All expenses of each such examination conducted shall be borne by such corporation. The commissioner shall make a full written report of each such examination of the corporation, certified to by the commissioner or the examiner in charge of such examinations. The commissioner shall furnish a copy of the report to the corporation examined not less than thirty days prior to filing the same in his or her office. If such corporation so requests in writing, within such thirty-day period, the commissioner shall consider the objections of such corporation to the report as proposed and shall not so file the report until after such modifications, if any, have been made therein as the commissioner deems proper. The report, when filed, shall be admissible in evidence in any action or proceeding brought by the commissioner against the corporation examined, or its officers or agents, and shall be prima facie evidence of the facts stated therein. The commissioner or his or her examiners may at any time testify and offer other proper evidence as to information secured during the course of an examination, whether or not a written report of the examination has at that time been either made, served or filed in the commissioner's office.

(b) For such purposes the commissioner, his or her deputies and employees shall have free access to all books, records, papers, documents and correspondence of any such corporation and such books, records, papers, documents and records shall be and remain in the State of West Virginia. The licenses of said corporation shall be automatically revoked if such books, records, papers, documents and records are taken outside the State of West Virginia without the prior written approval of the commissioner.

(c) The commissioner shall revoke the license of any such corporation which refuses to submit to such examination.

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§33-25-10a. Loss ratio.

If a corporation considers a loss ratio at the time of renewal of a policy, plan, or contract, the corporation shall, upon request of a subscriber, provide the loss ratio and the components of the loss ratio calculation to the 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.

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

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§33-25-11. Rules and regulations.

The commissioner is authorized to promulgate and adopt such rules and regulations relating to health care corporations as are necessary to discharge his duties and exercise his powers and to effectuate the provisions of this article and to protect and safeguard the interests of subscribers and the public of this state.

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§33-25-12. Required provisions in contracts made by corporation with physicians, dentists, etc., hospitals and other health agencies.

Each contract made by the corporation with any person (other than subscribers), corporation, association and institution, named or referred to in section three of this article shall contain the following provisions:

(a) That the person, corporation, association or institution 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 the person, corporation, association or institution will accept as full payment for services contracted for subscribers such compensation as is set forth in the contract between such person, corporation, association or institution and the corporation;

(c) That in the event a surplus remains after an annual accounting of the financial condition of the corporation, such surplus may be used by the corporation, upon an affirmative vote of a majority of its board of directors for the following purposes, in the order of priority stated below:

(1) To liquidate on a pro rata basis any obligation due any such person, corporation, association or institution in previous years;

(2) To return the original contributions for working capital, or any part thereof, on a pro rata basis;

(3) To reduce rates charged subscribers, or to expand the services rendered them.

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§33-25-13. Contracts to be furnished to subscribers; payments for subscribers by others; wage deductions.

(a) Every such corporation shall deliver to each subscriber to its health care plan a copy of the contract.

(b) A corporation may accept from private agencies, corporations, associations, groups or individuals, payment for or on behalf of any subscriber of all or any part of the cost of subscriptions for direct health care services to be rendered: Provided, That no employer or sponsor may deduct the proportionate share of such payment attributable to any employee or subscriber from that employee's or subscriber's wages or salary, without the prior written consent of the employee or subscriber. It shall be unlawful for any governmental agency to pay subscriptions for or on behalf of any subscriber.

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§33-25-14. Advancement of money to corporation.

Any person may advance to such corporation any sums of money necessary for its business or to enable it to comply with any requirements of law. Such advances and such interest thereon not exceeding six percent per annum, as may be agreed upon, shall not be a liability or a claim against the corporation or any of its assets, except as provided in this section and shall be reimbursed only out of the surplus earnings of such corporation. This section does not affect the power to borrow money which any such corporation possesses under other laws. No commissions or promotion expenses shall be paid by the corporation in connection with the advance of any such money to the corporation. The amount of any such advance that has not been repaid shall be reported in each annual statement of the corporation.

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§33-25-15.

Repealed.

Acts, 1991 Reg. Sess., Ch. 89.

WV Legislature

§33-25-16. Disposition of fees and charges.

All licenses or renewal fees, all auditing charges and any other income derived from this article shall be deposited with the treasurer of the State of West Virginia to the credit of the Insurance Commissioner to be used only for the cost of operation of the Insurance Commissioner's office.

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§33-25-17. Bonds of corporation officers and employees.

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

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§33-25-18. Annual audited financial report.

Every health care organization organized under the laws of this state is subject to the provisions of article thirty-three of this chapter.

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§33-25-19. Administrative supervision.

Every health care corporation subject to the provisions of this article is subject to the provisions of article thirty-four of this chapter.

WV Legislature

§33-25-20. 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.

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§33-25-21. 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 in the rate making and solvency determination of that insurer.

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§33-25-22. 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.

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§33-25-23. 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.

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§33-25-24. 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 nonparticipating 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 nonparticipating 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;

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(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 nonparticipating 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.

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