

WEST VIRGINIA LEGISLATURE

2018 REGULAR SESSION

Enrolled
Committee Substitute
for
Senate Bill 401

SENATORS WELD, FERNS, ROMANO, BALDWIN, AND

DRENNAN, *original sponsors*

[Passed March 10, 2018; in effect 90 days from passage]

FILED

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OFFICE WEST VIRGINIA
SECRETARY OF STATE

SB401

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1 AN ACT to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section,
2 designated §33-15-4p; to amend said code by adding thereto a new section, designated
3 §33-16-3bb; to amend said code by adding thereto a new section, designated §33-24-7q;
4 to amend said code by adding thereto a new section, designated §33-25-8n; and to amend
5 said code by adding thereto a new section, designated §33-25A-8p, all relating to requiring
6 specified coverage in health benefit plans for outpatient and inpatient treatment for
7 substance use disorders by July 1, 2019; defining terms; providing for rulemaking for the
8 Insurance Commissioner; setting forth time frames for coverage; and providing for
9 expedited grievances.

Be it enacted by the Legislature of West Virginia:

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4p. Substance use disorder.

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

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

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

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

9 (4) "Insurer" means the same as that term is defined in §33-15-2 of this code.

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

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

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

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

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

23 (1) Prescribed by a physician or psychiatrist licensed pursuant to the provisions of §30-
24 3-1 *et seq.* or §30-14-1 *et seq.* of this code or recommended by a psychologist licensed
25 pursuant to the provisions of §30-21-1 *et seq.* of this code; and

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

29 (d) The inpatient and outpatient treatment of substance use disorders shall be provided
30 when determined medically necessary by the covered person's physician, psychologist, or
31 psychiatrist. The facility shall notify the insurer of both the admission and the initial treatment
32 plan within 48 hours of the admission or initiation of treatment. If there is no in-network facility
33 immediately available for a covered person, an accident and sickness policy shall provide
34 necessary exceptions to its network to ensure admission in a treatment facility within 72 hours.
35 If a covered person is being treated at an out-of-network facility and an in-network facility
36 becomes available during the course of the treatment plan, an insurer may transfer the
37 covered person to the in-network facility.

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

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

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

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

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

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

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

64 (h) The Insurance Commissioner shall propose rules in accordance with the provisions
65 of §29A-3-1 *et seq.* of this code to develop a procedure for an expedited review of an adverse
66 decision as set forth in this section. The Legislature finds that for the purposes of §20A-3-15
67 of this code, an emergency exists requiring the promulgation of an emergency rule to respond
68 to the growing need in our state for substance abuse treatment.

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

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

75 (j) Medical necessity review shall use an evidence-based and peer-reviewed clinical
76 review tool. This tool shall be developed by the Insurance Commissioner. Rules shall ensure
77 that the tool is based on appropriate evidence-based criteria that has been peer reviewed.
78 The Insurance Commissioner shall propose rules for legislative approval in accordance with
79 the provisions of §29A-3-1 *et seq.* of this code to develop the tool.

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

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

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

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

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

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3bb. Substance use disorder.

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

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

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

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

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

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

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

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

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

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

23 (1) Prescribed by a physician or psychiatrist licensed pursuant to the provisions of §30-
24 3-1 *et seq.* or §30-14-1 *et seq.* of this code or recommended by a psychologist licensed
25 pursuant to the provisions of §30-21-1 *et seq.* of this code; and

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

29 (d) The inpatient and outpatient treatment of substance use disorders shall be provided
30 when determined medically necessary by the covered person's physician, psychologist, or
31 psychiatrist. The facility shall notify the health insurer of both the admission and the initial
32 treatment plan within 48 hours of the admission or initiation of treatment. If there is no in-
33 network facility immediately available for a covered person, a group accident and sickness
34 policy shall provide necessary exceptions to its network to ensure admission in a treatment
35 facility within 72 hours. If a covered person is being treated at an out-of-network facility and
36 an in-network facility becomes available during the course of the treatment plan, an insurer
37 may transfer the covered person to the in-network facility.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§33-24-7q. Substance use disorder.

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

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

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

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

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

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

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

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

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

20 (b) A health benefit plan offered by a health plan issuer that provides hospital or
21 medical expense benefits and is delivered, issued, executed, or renewed in this state, or
22 approved for issuance or renewal by the Insurance Commissioner, on or after January 1,
23 2019, shall provide benefits for inpatient and outpatient treatment of substance use disorder

24 at in-network facilities at the same level as other medical services offered by the health benefit
25 plan.

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

27 (1) Prescribed by a physician or psychiatrist licensed pursuant to the provisions of §30-
28 3-1 *et seq.* or §30-14-1 *et seq.* of this code or recommended by a psychologist licensed
29 pursuant to the provisions of §30-21-1 *et seq.* of this code; and

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

33 (d) The inpatient and outpatient treatment of substance use disorders shall be provided
34 when determined medically necessary by the covered person's physician, psychologist, or
35 psychiatrist. The facility shall notify the insurer of both the admission and the initial treatment
36 plan within 48 hours of the admission or initiation of treatment. If there is no in-network facility
37 immediately available for a covered person, a health benefit plan offered by a health plan
38 issuer shall provide necessary exceptions to its network to ensure admission in a treatment
39 facility within 72 hours. A health benefit plan may transfer a covered person to an in-network
40 facility if one becomes available during the course of the treatment plan. If a covered person
41 is being treated at an out-of-network facility and an in-network facility becomes available
42 during the course of the treatment plan, an insurer may transfer the covered person to the in-
43 network facility.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8n. Substance use disorder.

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

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

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

7 (3) “Insurance Commissioner” means the person appointed pursuant to the provisions
8 of §33-2-1 of this code.

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

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

13 (6) “Physician” or “psychiatrist” means a person licensed pursuant to the provisions of
14 either §30-3-1 *et seq.* or §30-3-14 *et seq.* of this code.

15 (7) “Psychologist” means a person licensed pursuant to the provisions of §30-21-1 *et*
16 *seq.* of this code.

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

20 (b) A health benefit plan offered by a health plan issuer that provides hospital or
21 medical expense benefits and is delivered, issued, executed, or renewed in this state, or
22 approved for issuance or renewal by the Insurance Commissioner, on or after January 1,
23 2019, shall provide benefits for inpatient and outpatient treatment of substance use disorder

24 at in-network facilities at the same level as other medical services offered by the health benefit
25 plan offered by a health plan issuer.

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

27 (1) Prescribed by a physician or psychiatrist licensed pursuant to the provisions of §30-
28 3-1 *et seq.* or §30-14-1 *et seq.* of this code or recommended by a psychologist licensed
29 pursuant to the provisions of §30-21-1 *et seq.* of this code; and

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

33 (d) The inpatient and outpatient treatment of substance use disorders shall be provided
34 when determined medically necessary by the covered person's physician, psychologist, or
35 psychiatrist. The facility shall notify the insurer of both the admission and the initial treatment
36 plan within 48 hours of the admission or initiation of treatment. If there is no in-network facility
37 immediately available for a covered person, a health benefit plan offered by a health plan
38 issuer shall provide necessary exceptions to its network to ensure admission in a treatment
39 facility within 72 hours. If a covered person is being treated at an out-of-network facility and
40 an in-network facility becomes available during the course of the treatment plan, an insurer
41 may transfer the covered person to the in-network facility.

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

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

47 (g)(1) If an insurer determines that continued inpatient care in a facility is no longer
48 medically necessary, the insurer shall, within 72 hours, provide written notice to the covered

49 person and the covered person's physician of its decision and the right to file for an expedited
50 review of an adverse decision.

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8p. Substance use disorder.

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

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

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

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

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

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

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

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

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

20 (b) A health benefit plan offered by a health plan issuer that provides hospital or
21 medical expense benefits and is delivered, issued, executed, or renewed in this state, or
22 approved for issuance or renewal by the Insurance Commissioner, on or after January 1,
23 2019, shall provide benefits for inpatient and outpatient treatment of substance use disorder

24 at in-network facilities at the same level as other medical benefits offered by the health benefit
25 plan offered by a health plan insurer.

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

27 (1) Prescribed by a physician or psychiatrist licensed pursuant to the provisions of §30-
28 3-1 *et seq.* or §30-14-1 *et seq.* of this code or recommended by a psychologist licensed
29 pursuant to the provisions of §30-21-1 *et seq.* of this code; and

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

33 (d) The inpatient and outpatient treatment of substance use disorders shall be provided
34 when determined medically necessary by the covered person's physician, psychologist, or
35 psychiatrist. The facility shall notify the insurer of both the admission and the initial treatment
36 plan within 48 hours of the admission or initiation of treatment. If there is no in-network facility
37 immediately available for a covered person, a health benefit plan offered by a health plan
38 issuer shall provide necessary exceptions to its network to ensure admission in a treatment
39 facility within 72 hours. If a covered person is being treated at an out-of-network facility and
40 an in-network facility becomes available during the course of the treatment plan, an insurer
41 may transfer the covered person to the in-network facility.

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

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

47 (g)(1) If an insurer determines that continued inpatient care in a facility is no longer
48 medically necessary, the insurer shall, within 72 hours, provide written notice to the covered

49 person and the covered person's physician of its decision and the right to file for an expedited
50 review of an adverse decision.

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

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

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

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

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

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

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

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

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

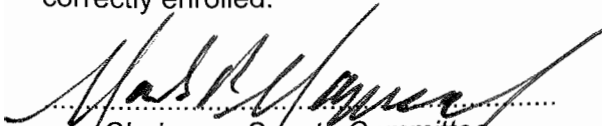
87 (l) The days per plan year of benefits shall be computed based on inpatient days. One
88 or more unused inpatient days may be exchanged for two outpatient visits. All extended
89 outpatient services such as partial hospitalization and intensive outpatient, shall be
90 considered inpatient days for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

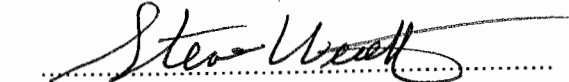
92 (m) Except as provided in this section, the benefits and cost-sharing shall be provided
93 to the same extent as for any other medical condition covered under the contract.

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

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


The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.


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Chairman, Senate Committee

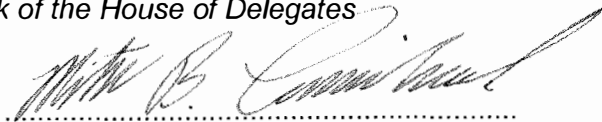

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Vice-Chairman, House Committee

Originated in the Senate.

In effect 90 days from passage.


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Clerk of the Senate


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Clerk of the House of Delegates


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President of the Senate

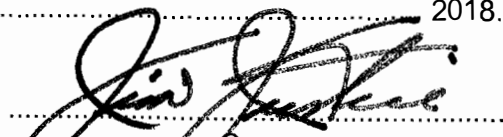

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Speaker of the House of Delegates

OFFICE WEST VIRGINIA
SECRETARY OF STATE

2018 MAR 21 A 9:42

FILED

The within is approved this the 27th
Day of March 2018.


.....
Governor

PRESENTED TO THE GOVERNOR

MAR 21 2018

Time 11:57 am