

# WEST VIRGINIA LEGISLATURE

## 2018 REGULAR SESSION

Introduced

### Senate Bill 401

FISCAL  
NOTE

BY SENATORS WELD, FERNS, ROMANO, BALDWIN, AND

DRENNAN

[Introduced January 26, 2018; Referred  
to the Committee on Health and Human Resources; and  
then to the Committee on the Judiciary]

1 A BILL 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; defining terms; providing for rulemaking for the Insurance  
 8 Commissioner; setting forth timeframes for coverage; and providing for expedited  
 9 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 shall have the following meaning:

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, and  
 4 as appropriate, the discharge plans.

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

7 (3) “Insurance Commissioner” means the person appointed pursuant to the provisions  
 8 of article two of this chapter.

9 (4) “Insurer” means the same as that term is defined in section two-a of this article.

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 as that term is defined by the American  
15 Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth  
16 Edition and any subsequent editions 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 a psychologist licensed pursuant to the  
25 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 benefits for the first 180 days per plan year of inpatient and outpatient  
30 treatment of substance use disorder shall be provided when determined medically necessary  
31 by the covered person's physician, psychologist or psychiatrist without the imposition of any  
32 prior authorization or other prospective utilization management requirements. The facility  
33 shall notify the insurer of both the admission and the initial treatment plan within 48 hours of  
34 the admission or initiation of treatment. If there is no in-network facility immediately available  
35 for a covered person, an accident and sickness policy shall provide necessary exceptions to  
36 its network to ensure admission in a treatment facility within 72 hours. If a person is being  
37 treated at an out-of-network facility and an in-network facility becomes available during the  
38 course of the treatment plan, an insurer may transfer a person to the in-network facility.

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

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

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

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

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

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

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

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

70 (i)(1) The benefits for the first 28 days of intensive outpatient or partial hospitalization  
71 services shall be provided without any retrospective review of medical necessity and medical  
72 necessity shall be as determined by the covered person's physician.

73 (2) The benefits for days 29 and thereafter of intensive outpatient or partial  
74 hospitalization services shall be subject to a retrospective review of the medical necessity of  
75 the services.

76 (j) Benefits for inpatient and outpatient treatment of substance use disorder after the  
77 first 180 days per plan year shall be subject to the medical necessity determination of the  
78 insurer and may be subject to prior authorization or retrospective review and other utilization  
79 management requirements.

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

85 (l) 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,  
87 psychologist or psychiatrist without the imposition of any prior authorization or other  
88 prospective utilization management requirements.

89 (m) The first 180 days per plan year of benefits shall be computed based on inpatient  
90 days. One or more unused inpatient days may be exchanged for two outpatient visits. All

91 extended outpatient services such as partial hospitalization and intensive outpatient, shall be  
92 deemed inpatient days for the purpose of the visit-to-day exchange provided in this  
93 subsection.

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

96 (o) 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 (p) The provisions of this section shall apply to all insurance contracts in which the  
100 insurer 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 meaning:

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, and  
4 as appropriate, the discharge plans.

5 (2) “Covered person” means an individual for whom coverage has been provided  
6 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 as that term is defined by the American  
15 Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth  
16 Edition and any subsequent editions 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 a psychologist licensed pursuant to the  
25 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 benefits for the first 180 days per plan year of inpatient and outpatient  
30 treatment of substance use disorder shall be provided when determined medically necessary  
31 by the covered person’s physician, psychologist or psychiatrist without the imposition of any  
32 prior authorization or other prospective utilization management requirements. The facility  
33 shall notify the health insurer of both the admission and the initial treatment plan within 48  
34 hours of the admission or initiation of treatment. If there is no in-network facility immediately  
35 available for a covered person, a group accident and sickness policy shall provide necessary  
36 exceptions to its network to ensure admission in a treatment facility within 72 hours. If a  
37 person is being treated at an out-of-network facility and an in-network facility becomes  
38 available during the course of the treatment plan, an insurer may transfer a person to the in-  
39 network facility.

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

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

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

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

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

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

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



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

71 (i)(1) The benefits for the first 28 days of intensive outpatient or partial hospitalization  
72 services shall be provided without any retrospective review of medical necessity and medical  
73 necessity shall be as determined by the covered person's physician.

74 (2) The benefits for days 29 and thereafter of intensive outpatient or partial  
75 hospitalization services shall be subject to a retrospective review of the medical necessity of  
76 the services.

77 (j) Benefits for inpatient and outpatient treatment of substance use disorder after the  
78 first 180 days per plan year shall be subject to the medical necessity determination of the  
79 health insurer and may be subject to prior authorization or retrospective review and other  
80 utilization management requirements.

81 (k) 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 (l) 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,  
87 psychologist or psychiatrist without the imposition of any prior authorization or other  
88 prospective utilization management requirements.

89 (m) The first 180 days per plan year of benefits shall be computed based on inpatient  
90 days. One or more unused inpatient days may be exchanged for two outpatient visits. All  
91 extended outpatient services such as partial hospitalization and intensive outpatient, shall be

92 deemed inpatient days for the purpose of the visit-to-day exchange provided in this  
93 subsection.

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

96 (o) 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 (p) The provisions of this section shall apply to all insurance contracts in which the  
100 health 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 shall have the following meaning:

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, and  
4 as appropriate, the discharge plans.

5 (2) “Covered person” means an individual for whom coverage has been provided  
6 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 as that term is defined by the American  
18 Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth  
19 Edition and any subsequent editions 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 a psychologist licensed pursuant to the  
29 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 benefits for the first 180 days per plan year of inpatient and outpatient  
34 treatment of substance use disorder shall be provided when determined medically necessary  
35 by the covered person’s physician, psychologist or psychiatrist without the imposition of any  
36 prior authorization or other prospective utilization management requirements. The facility  
37 shall notify the insurer of both the admission and the initial treatment plan within 48 hours of  
38 the admission or initiation of treatment. If there is no in-network facility immediately available

39 for a covered person, a health benefit plan offered by a health plan issuer shall provide  
40 necessary exceptions to its network to ensure admission in a treatment facility within 72 hours.  
41 A health benefit plan may transfer a person to an in-network facility if one becomes available  
42 during the course of the treatment plan. If a person is being treated at an out-of-network facility  
43 and an in-network facility becomes available during the course of the treatment plan, an  
44 insurer may transfer a person to the in-network facility.

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

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

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

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

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

61 (4) If the insurer's determination is upheld and it is determined continued inpatient care  
62 is not medically necessary, the insurer shall remain responsible to provide benefits for the  
63 inpatient care through the day following the date the determination is made and the covered

64 person shall only be responsible for any applicable copayment, deductible and coinsurance  
65 for the stay through that date as applicable under the contract.

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

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

76 (i)(1) The benefits for the first 28 days of intensive outpatient or partial hospitalization  
77 services shall be provided without any retrospective review of medical necessity and medical  
78 necessity shall be as determined by the covered person's physician.

79 (2) The benefits for days 29 and thereafter of intensive outpatient or partial  
80 hospitalization services shall be subject to a retrospective review of the medical necessity of  
81 the services.

82 (j) Benefits for inpatient and outpatient treatment of substance use disorder after the  
83 first 180 days per plan year shall be subject to the medical necessity determination of the  
84 insurer and may be subject to prior authorization or, retrospective review and other utilization  
85 management requirements.

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

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

94 (m) The first 180 days per plan year of benefits shall be computed based on inpatient  
 95 days. One or more unused inpatient days may be exchanged for two outpatient visits. All  
 96 extended outpatient services such as partial hospitalization and intensive outpatient, shall be  
 97 deemed inpatient days for the purpose of the visit-to-day exchange provided in this  
 98 subsection.

99 (n) Except as herein provided, the benefits and cost-sharing shall be provided to the  
 100 same extent as for any other medical condition covered under the contract.

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

104 (p) The provisions of this section shall apply to all insurance contracts in which the  
 105 insurer 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 shall have the following meaning:

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, and  
 4 as appropriate, the discharge plans.

5 (2) “Covered person” means an individual for whom coverage has been provided  
 6 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 article §30-  
16 21-1 et seq. of this code.

17           (8) “Substance use disorder” means as that term is defined by the American  
18 Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth  
19 Edition and any subsequent editions 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 a psychologist licensed pursuant to the  
29 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 benefits for the first 180 days per plan year of inpatient and outpatient  
34 treatment of substance use disorder shall be provided when determined medically necessary

35 by the covered person's physician, psychologist or psychiatrist without the imposition of any  
36 prior authorization or other prospective utilization management requirements. The facility  
37 shall notify the insurer of both the admission and the initial treatment plan within 48 hours of  
38 the admission or initiation of treatment. If there is no in-network facility immediately available  
39 for a covered person, a health benefit plan offered by a health plan issuer shall provide  
40 necessary exceptions to its network to ensure admission in a treatment facility within 72 hours.  
41 If a person is being treated at an out-of-network facility and an in-network facility becomes  
42 available during the course of the treatment plan, an insurer may transfer a person to the in-  
43 network facility.

44 (e) Providers of treatment for substance use disorder 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 such 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 shall remain responsible to provide benefits for the  
62 inpatient care through the day following the date the determination is made and the covered  
63 person shall only be responsible for any applicable copayment, deductible and coinsurance  
64 for the 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 shall only be responsible for any applicable cost-  
69 sharing, and 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 section  
73 §29A-3-15 of this code, an emergency exists requiring the promulgation of an emergency rule  
74 to respond to the growing need in our state for substance abuse treatment.

75 (i)(1) The benefits for the first 28 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 as determined by the covered person's physician.

78 (2) The benefits for days 29 and thereafter of intensive outpatient or partial  
79 hospitalization services shall be subject to a retrospective review of the medical necessity of  
80 the services.

81 (j) Benefits for inpatient and outpatient treatment of substance use disorder after the  
82 first 180 days per plan year shall be subject to the medical necessity determination of the  
83 insurer and may be subject to prior authorization or, retrospective review and other utilization  
84 management requirements.

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

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

93 (m) The first 180 days per plan year of benefits shall be computed based on inpatient  
94 days. One or more unused inpatient days may be exchanged for two outpatient visits. All  
95 extended outpatient services such as partial hospitalization and intensive outpatient, shall be  
96 deemed inpatient days for the purpose of the visit to day exchange provided in this subsection.

97 (n) Except as herein provided, the benefits and cost-sharing shall be provided to the  
98 same extent as for any other medical condition covered under the contract.

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

102 (p) The provisions of this section shall apply to all insurance contracts in which the  
103 insurer 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 shall have the following meaning:

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, and  
4 as appropriate, the discharge plans.

5 (2) "Covered person" means an individual for whom coverage has been provided  
6 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 as that term is defined by the American  
18 Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth  
19 Edition and any subsequent editions 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 a psychologist licensed pursuant to the  
29 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 benefits for the first 180 days per plan year of inpatient and outpatient  
34 treatment of substance use disorder shall be provided when determined medically necessary  
35 by the covered person's physician, psychologist or psychiatrist without the imposition of any  
36 prior authorization or other prospective utilization management requirements. The facility  
37 shall notify the insurer of both the admission and the initial treatment plan within 48 hours of  
38 the admission or initiation of treatment. If there is no in-network facility immediately available  
39 for a covered person, a health benefit plan offered by a health plan issuer shall provide  
40 necessary exceptions to its network to ensure admission in a treatment facility within 72 hours.  
41 If a person is being treated at an out-of-network facility and an in-network facility becomes  
42 available during the course of the treatment plan, an insurer may transfer a person to the in-  
43 network facility.

44 (e) Providers of treatment for substance use disorder 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 such 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 shall remain responsible to provide benefits for the  
62 inpatient care through the day following the date the determination is made and the covered  
63 person shall only be responsible for any applicable copayment, deductible and coinsurance  
64 for the 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 shall only be responsible for any applicable cost-  
69 sharing, and 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 28 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 as determined by the covered person's physician.

78 (2) The benefits for days 29 and thereafter of intensive outpatient or partial  
79 hospitalization services shall be subject to a retrospective review of the medical necessity of  
80 the services.

81 (j) Benefits for inpatient and outpatient treatment of substance use disorder after the  
82 first 180 days per plan year shall be subject to the medical necessity determination of the  
83 insurer and may be subject to prior authorization or, retrospective review and other utilization  
84 management requirements.

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

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

93 (m) The first 180 days per plan year of benefits shall be computed based on inpatient  
94 days. One or more unused inpatient days may be exchanged for two outpatient visits. All  
95 extended outpatient services such as partial hospitalization and intensive outpatient, shall be  
96 deemed inpatient days for the purpose of the visit-to-day exchange provided in this  
97 subsection.

98 (n) Except as herein provided, the benefits and cost-sharing shall be provided to the  
99 same extent as for any other medical condition covered under the contract.

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

103 (p) The provisions of this section shall apply to all insurance contracts in which the  
104 insurer has reserved the right to change the premium.

NOTE: The purpose of this bill is to require specified coverage in health benefit plans for

outpatient and inpatient treatment for substance use disorders.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.