

WEST VIRGINIA LEGISLATURE

2024 REGULAR SESSION

Introduced

House Bill 4613

By Delegate Young

[Introduced January 11, 2024; Referred to the
Committee on Health and Human Resources then
Finance]

1 A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section,
 2 designated §5-16-30; to amend said code by adding thereto a new section, designated
 3 §33-15-4x; to amend said code by adding thereto a new section, designated §33-16-3ii; to
 4 amend said code by adding thereto a new section, designated §33-24-7x; to amend said
 5 code by adding thereto a new section, designated §33-25-8u; to amend said code by
 6 adding thereto a new section, designated §33-25A-8x; and to amend said code by adding
 7 thereto a new article, designated §33-57A-1, §33-57A-2, §33-57A-3, §33-57A-4, and §33-
 8 57A-5, all relating to creating the Mental Health and Substance Use Disorders Insurance
 9 Coverage Protection Act; requiring certain insurance policies to provide coverage for
 10 medically necessary treatment of mental health and substance use disorders; defining
 11 terms; mandating generally accepted standards be followed when making medical
 12 necessity determinations; and prohibiting discretionary clauses.

Be it enacted by the Legislature of West Virginia:

**CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE
 GOVERNOR, SECRETARY OF STATE AND ATTORNEY GENERAL;
 BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES,
 COMMISSIONS, OFFICES, PROGRAMS, ETC.**

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

§5-16-30. Additional mental health and substance use disorders coverage.

1 Notwithstanding any provision of this code to the contrary, a policy, plan, or contract that is
 2 issued or renewed on or after January 1, 2025, and that is subject to this article, shall provide, at a
 3 minimum, the coverage required by §33-57A-1 et seq. of this code, commonly known as the
 4 Mental Health and Substance Use Disorders Insurance Coverage Protection Act.

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4x. Additional mental health and substance use disorders coverage.

1 Notwithstanding any provision of this code to the contrary, a policy, plan, or contract that is
2 issued or renewed on or after January 1, 2025, and that is subject to this article, shall provide, at a
3 minimum, the coverage required by §33-57A-1 et seq. of this code, commonly known as the
4 Mental Health and Substance Use Disorders Insurance Coverage Protection Act.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3ii. Additional mental health and substance use disorders coverage.

1 Notwithstanding any provision of this code to the contrary, a policy, plan, or contract that is
2 issued or renewed on or after January 1, 2025, and that is subject to this article, shall provide, at a
3 minimum, the coverage required by §33-57A-1 et seq. of this code, commonly known as the
4 Mental Health and Substance Use Disorders Insurance Coverage Protection Act.

ARTICLE 24. HOSPITAL MEDICAL AND DENTAL CORPORATIONS.

§33-24-7x. Additional mental health and substance use disorders coverage.

1 Notwithstanding any provision of this code to the contrary, a policy, plan, or contract that is
2 issued or renewed on or after January 1, 2025, and that is subject to this article, shall provide, at a
3 minimum, the coverage required by §33-57A-1 et seq. of this code, commonly known as the
4 Mental Health and Substance Use Disorders Insurance Coverage Protection Act.

ARTICLE 25. HEALTHCARE CORPORATION.

§33-25-8u. Additional mental health and substance use disorders coverage.

1 Notwithstanding any provision of this code to the contrary, a policy, plan, or contract that is
2 issued or renewed on or after January 1, 2025, and that is subject to this article, shall provide, at a
3 minimum, the coverage required by §33-57A-1 et seq. of this code, commonly known as the
4 Mental Health and Substance Use Disorders Insurance Coverage Protection Act.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8x. Additional mental health and substance use disorders coverage.

1 Notwithstanding any provision of this code to the contrary, a policy, plan, or contract that is
2 issued or renewed on or after January 1, 2025, and that is subject to this article, shall provide, at a
3 minimum, the coverage required by §33-57A-1 et seq. of this code, commonly known as the
4 Mental Health and Substance Use Disorders Insurance Coverage Protection Act.

ARTICLE 57A. MENTAL HEALTH AND SUBSTANCE USE DISORDERS INSURANCE

COVERAGE PROTECTION.

§33-57A-1. Title.

1 This article shall be known as the Mental Health and Substance Use Disorders Insurance
2 Coverage Protection Act.

§33-57A-2. Definitions.

1 The following definitions apply for purposes of this article:

2 "Generally accepted standards of mental health and substance use disorder care" means
3 standards of care and clinical practice that are generally recognized by health care providers
4 practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology,
5 addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based
6 sources reflecting generally accepted standards of mental health and substance use disorder care
7 include peer-reviewed scientific studies and medical literature, recommendations of nonprofit
8 health care provider professional associations and specialty societies, including, but not limited to,
9 patient placement criteria and clinical practice guidelines, recommendations of federal
10 government agencies, and drug labeling approved by the United States Food and Drug
11 Administration.

12 "Medically necessary treatment of a mental health or substance use disorder" means a
13 service or product addressing the specific needs of that patient, for the purpose of screening,
14 preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms,

15 including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner
16 that is all of the following:

17 (1) In accordance with the generally accepted standards of mental health and substance
18 use disorder care.

19 (2) Clinically appropriate in terms of type, frequency, extent, site, and duration.

20 (3) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience
21 of the patient, treating physician, or other health care provider.

22 "Mental health and substance use disorders" means a mental health condition or
23 substance use disorder that falls under any of the diagnostic categories listed in the mental and
24 behavioral disorders chapter of the most recent edition of the World Health Organization's
25 International Statistical Classification of Diseases and Related Health Problems, or that is listed in
26 the most recent version of the American Psychiatric Association's Diagnostic and Statistical
27 Manual of Mental Disorders. Changes in terminology, organization, or classification of mental
28 health and substance use disorders in future versions of the American Psychiatric Association's
29 Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's
30 International Statistical Classification of Diseases and Related Health Problems may not affect the
31 conditions covered by this section as long as a condition is commonly understood to be a mental
32 health or substance use disorder by health care providers practicing in relevant clinical specialties.

33 "Utilization review" means either of the following:

34 (1) Prospectively, retrospectively, or concurrently reviewing and approving, modifying,
35 delaying, or denying, based in whole or in part on medical necessity, requests by health care
36 providers, insureds, or their authorized representatives for coverage of health care services prior
37 to, retrospectively or concurrent with the provision of health care services to insureds.

38 (2) Evaluating the medical necessity, appropriateness, level of care, service intensity,
39 efficacy, or efficiency of health care services, benefits, procedures, or settings, under any
40 circumstances, to determine whether a health care service or benefit subject to a medical

41 necessity coverage requirement in an insurance policy is covered as medically necessary for an
42 insured.

43 "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by
44 an insurer to conduct utilization review.

§33-57A-3. Coverage for Medically Necessary Mental Health and Substance Use Disorder
Services.

1 (a) Every insurance policy issued, amended, or renewed on or after January 1, 2025, that
2 provides hospital, medical, or surgical coverage shall provide coverage for medically necessary
3 treatment of mental health and substance use disorders.

4 (b) An insurer may not limit benefits or coverage for chronic or pervasive mental health and
5 substance use disorders to short-term or acute treatment at any level of care placement.

6 (c) All medical necessity determinations made by the insurer concerning service intensity,
7 level of care placement, continued stay, and transfer or discharge of insureds diagnosed with
8 mental health and substance use disorders shall be conducted in accordance with the
9 requirements of §33-57A-4 of this code.

10 (d) An insurer that authorizes a specific type of treatment by a provider pursuant to this
11 section may not rescind or modify the authorization after the provider renders the health care
12 service in good faith and pursuant to this authorization for any reason, including, but not limited to,
13 the insurer's subsequent rescission, cancellation, or modification of the insured's or policyholder's
14 contract, or the insurer's subsequent determination that it did not make an accurate determination
15 of the insured's or policyholder's eligibility. This section may not be construed to expand or alter
16 the benefits available to the insured or policyholder under an insurance policy.

17 (e) If services for the medically necessary treatment of a mental health or substance use
18 disorder are not available in network within the geographic and timeliness access standards set by
19 law or regulation, the insurer shall arrange coverage to ensure the delivery of medically necessary
20 out-of-network services and any medically necessary follow-up services that, to the maximum

21 extent possible, meet those geographic and timely access standards. As used in this subsection,
22 to "arrange coverage to ensure the delivery of medically necessary out-of-network services"
23 includes, but is not limited to, providing services to secure medically necessary out-of-network
24 options that are available to the insured within geographic and timely access standards. The
25 insured shall pay no more in total for benefits rendered than the cost sharing that the insured
26 would pay for the same covered services received from an in-network provider.

27 (f) An insurer may not limit benefits or coverage for medically necessary services on the
28 basis that those services should be or could be covered by a public entitlement program, including,
29 but not limited to, special education or an individualized education program, Medicaid, Medicare,
30 Supplemental Security Income, or Social Security Disability Insurance, and may not include or
31 enforce a contract term that excludes otherwise covered benefits on the basis that those services
32 should be or could be covered by a public entitlement program.

33 (g) An insurer may not adopt, impose, or enforce terms in its policies or provider
34 agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of
35 this section.

36 (h) If the insurance commissioner determines that an insurer has violated this section, the
37 commissioner may, after appropriate notice and opportunity for hearing, by order, assess a civil
38 penalty not to exceed \$5,000 for each violation, or, if a violation was willful, a civil penalty not to
39 exceed \$10,000 for each violation. The civil penalties available to the commissioner pursuant to
40 this section are not exclusive and may be sought and employed in combination with any other
41 remedies available to the commissioner under this code.

§33-57A-4. Medical Necessity Determinations Must Follow Generally Accepted Standards.

1 (a) An insurer that provides hospital, medical, or surgical coverage shall base any medical
2 necessity determination or the utilization review criteria that the insurer, and any entity acting on
3 the insurer's behalf, applies to determine the medical necessity of health care services and
4 benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders

5 on current generally accepted standards of mental health and substance use disorder care as
6 defined in §33-57A-2 of this code. All denials and appeals shall be reviewed by a professional with
7 the same level of education and experience of the provider requesting the authorization.

8 (b) In conducting utilization review of all covered health care services and benefits for the
9 diagnosis, prevention, and treatment of mental health and substance use disorders in children,
10 adolescents, and adults, an insurer shall apply the level of care placement criteria and practice
11 guidelines set forth in the most recent versions of such criteria and practice guidelines, developed
12 by the nonprofit professional association for the relevant clinical specialty.

13 (c) In conducting utilization review involving level of care placement decisions or any other
14 patient care decisions that are within the scope of the sources specified in subsection (b) of this
15 section, an insurer may not apply different, additional, conflicting, or more restrictive utilization
16 review criteria than the criteria and guidelines set forth in those sources. For all level of care
17 placement decisions, the insurer shall authorize placement at the level of care consistent with the
18 insured's score using the relevant level of care placement criteria and guidelines as specified in
19 subsection (b) of this section. If that level of placement is not available, the insurer shall authorize
20 the next higher level of care. If there is a disagreement, the insurer shall provide full detail of its
21 scoring using the relevant level of care placement criteria and guidelines as specified in
22 subsection (b) of this section to the provider of the service.

23 (d) To ensure the proper use of the criteria described in subsection (b) of this section, every
24 insurer shall do all of the following:

25 (1) Sponsor a formal education program by nonprofit clinical specialty associations to
26 educate the insurer's staff, including any third parties contracted with the insurer to review claims,
27 conduct utilization reviews, or make medical necessity determinations about the clinical review
28 criteria.

29 (2) Make the education program available to other stakeholders, including the insurer's
30 participating providers and covered lives.

31 (3) Provide, at no cost, the clinical review criteria and any training material or resources to
32 providers and insured patients.

33 (4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny
34 care, and support the appeals process.

35 (5) Conduct interrater reliability testing to ensure consistency in utilization review decision
36 making covering how medical necessity decisions are made. This assessment shall cover all
37 aspects of utilization review as defined in this article.

38 (6) Run interrater reliability reports about how the clinical guidelines are used in
39 conjunction with the utilization management process and parity compliance activities.

40 (7) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not
41 met, immediately provide for the remediation of poor interrater reliability and interrater reliability
42 testing for all new staff before they can conduct utilization review without supervision.

43 (e) This section applies to all health care services and benefits for the diagnosis,
44 prevention, and treatment of mental health and substance use disorders covered by an insurance
45 policy, including prescription drugs.

46 (f) This section applies to an insurer that covers hospital, medical, or surgical expenses
47 and conducts utilization review as defined in this section, and any entity or contracting provider
48 that performs utilization review or utilization management functions on an insurer's behalf.

49 (g) If the commissioner determines that an insurer has violated this section, the
50 commissioner may, after appropriate notice and opportunity for hearing in accordance with this
51 code, by order, assess a civil penalty not to exceed \$5,000 for each violation, or, if a violation was
52 willful, a civil penalty not to exceed \$10,000 for each violation. The civil penalties available to the
53 commissioner pursuant to this section are not exclusive and may be sought and employed in
54 combination with any other remedies available to the commissioner under this code.

55 (h) An insurer may not adopt, impose, or enforce terms in its policies or provider
56 agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of

57 this section.

§33-57A-5. Discretionary Clauses Prohibited.

1 (a) If an insurer contract offered, issued, delivered, amended, or renewed on or after
2 January 1, 2025, contains a provision that reserves discretionary authority to the insurer, or an
3 agent of the insurer, to determine eligibility for benefits or coverage, to interpret the terms of the
4 contract, or to provide standards of interpretation or review that are inconsistent with the laws of
5 this state, that provision is void and unenforceable.

6 (b) For purposes of this section, the term "discretionary authority" means a contract
7 provision that has the effect of conferring discretion on an insurer or other claims administrator
8 determine entitlement to benefits or interpret contract language that, in turn, could lead to a
9 deferential standard of review by a reviewing court.

10 (c) This section does not prohibit an insurer from including a provision in a contract that
11 informs an insured that, as part of its routine operations, the plan applies the terms of its contracts
12 for making decisions, including making determinations regarding eligibility, receipt of benefits and
13 claims, or explaining policies, procedures, and processes, so long as the provision could not give
14 rise to a deferential standard of review by a reviewing court.

NOTE: The purpose of this bill is to create the Mental Health and Substance Use Disorders Insurance Coverage Protection Act.

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