

# **WEST VIRGINIA LEGISLATURE**

**2018 REGULAR SESSION**

**Committee Substitute**

**for**

**Senate Bill 401**

BY SENATORS WELD, FERNS, ROMANO, BALDWIN, AND

DRENNAN

[Originating in the Committee on the Judiciary;

Reported on February 26, 2018]

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 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 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,  
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 §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 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 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,  
82 psychologist, or psychiatrist without the imposition of any prior authorization or other  
83 prospective utilization 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 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,  
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 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 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 (i) 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,  
81 psychologist, or psychiatrist without the imposition of any prior authorization or other  
82 prospective utilization 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 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,  
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 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 inpatient and outpatient treatment of substance use disorders shall be  
34 provided when determined medically necessary by the covered person's physician,  
35 psychologist, or psychiatrist. The facility shall notify the insurer of both the admission and the  
36 initial treatment plan within 48 hours of the admission or initiation of treatment. If there is no  
37 in-network facility immediately available for a covered person, a health benefit plan offered by  
38 a health plan issuer shall provide necessary exceptions to its network to ensure admission in  
39 a treatment facility within 72 hours. A health benefit plan may transfer a covered person to an  
40 in-network facility if one becomes available during the course of the treatment plan. If a  
41 covered person is being treated at an out-of-network facility and an in-network facility  
42 becomes available during the course of the treatment plan, an insurer may transfer the  
43 covered person to the in-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,  
87 psychologist, or psychiatrist without the imposition of any prior authorization or other  
88 prospective utilization 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 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,  
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 article §30-  
16 21-1 *et 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 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 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 section  
71 §29A-3-15 of this code, an emergency exists requiring the promulgation of an emergency rule  
72 to respond 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,  
85 psychologist, or psychiatrist without the imposition of any prior authorization or other  
86 prospective utilization 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 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,  
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 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 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,  
85 psychologist, or psychiatrist without the imposition of any prior authorization or other  
86 prospective utilization 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.