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]

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

Be it enacted by the Legislature of West Virginia:

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4p. Substance use disorder.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3bb. Substance use disorder.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(o) The provisions of this section apply to all insurance contracts in which the 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.

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

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

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

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

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

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

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

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

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

(b) A health benefit plan offered by a health plan issuer that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this state, or

approved for issuance or renewal by the Insurance Commissioner, on or after January 1, 2019, shall provide benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities at the same level as other medical services offered by the health benefit plan.

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

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

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

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

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

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

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

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

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

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

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

(h) The Insurance Commissioner shall propose rules in accordance with the provisions of §29A-3-1 *et seq.* of this code to develop a procedure for an expedited review of an adverse decision as set forth in this section. The Legislature finds that for the purposes of §29A-3-15

of this code, an emergency exists requiring the promulgation of an emergency rule to respond to the growing need in our state for substance abuse treatment.

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

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

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

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

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

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

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

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

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8n. Substance use disorder.

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

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

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

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

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

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

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

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

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

(b) A health benefit plan offered by a health plan issuer that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this state, or approved for issuance or renewal by the Insurance Commissioner, on or after January 1,

2019, shall provide benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities at the same level as other medical services offered by the health benefit plan offered by a health plan issuer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8p. Substance use disorder.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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