

# WEST VIRGINIA LEGISLATURE

## 2021 REGULAR SESSION

Introduced

### House Bill 2560

FISCAL  
NOTE

BY DELEGATES PUSHKIN AND WALKER

[Introduced February 16, 2021; Referred to the  
Committee on Banking and Insurance then Finance]

1 A BILL to amend the Code of West Virginia, 1931, as amended by adding thereto a new section,  
 2 designated §5-16-7h; 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;  
 4 to amend said code by adding thereto a new section, designated §33-24-7x, to amend  
 5 said code by adding thereto a new section, designated §33-25-8u; and to amend said  
 6 code by adding thereto a new section, designated §33-25A-8x, all relating to requiring the  
 7 Public Employees Agency and other health insurance providers to provide mental health  
 8 parity between behavioral health, mental health, substance use disorders and medical  
 9 and surgical procedures; providing definitions; providing mandatory coverage; providing  
 10 for mandatory annual reporting; providing for rulemaking; and setting forth an effective  
 11 date.

*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.**

**§5-16-7h. Mental health parity.**

1 (a) As used in this section, the following words and phrases have the meaning given them  
 2 in this section unless the context clearly indicates otherwise:

3 “Behavioral, Mental Health and Substance Use Disorder” means a condition or disorder,  
 4 regardless of etiology, that may be the result of a combination of genetic and environmental  
 5 factors and that falls under any of the diagnostic categories listed in the mental disorders section  
 6 of the most recent version of:

7 (1) The International Statistical Classification of Diseases and Related Health Problems;

8 (2) The Diagnostic and Statistical Manual of Mental Disorders; or

9 (3) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy  
10 and Early Childhood; and

11 Includes autism spectrum disorder.

12 (b) The Public Employees Insurance Agency is required to provide coverage for the  
13 prevention of, screening for, and treatment of behavioral, mental health, and substance use  
14 disorders that is no less extensive than the coverage provided for any physical illness and that  
15 complies with the requirements of this section. This screening shall include, but is not limited to,  
16 unhealthy alcohol use for adults, substance use for adults and adolescents, and depression  
17 screening for adolescents and adults.

18 (c) The Public Employees Insurance Agency shall:

19 (1) Include coverage and reimbursement for behavioral health screenings using a  
20 validated screening tool for behavioral health, which coverage and reimbursement is no less  
21 extensive than the coverage and reimbursement for the annual physical examination.

22 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR  
23 146.136(c)(4), or any successor regulation, regarding any limitations that are not expressed  
24 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to  
25 the limitations and examples listed in 45 CFR 146.136(c)(4)(ii) and (c)(4)(iii), or any successor  
26 regulation and 78 FR 68246, include the methods by which the Public Employees Insurance  
27 Agency establishes and maintains its provider network and responds to deficiencies in the ability  
28 of its networks to provide timely access to care;

29 (3) Comply with the financial requirements and quantitative treatment limitations specified  
30 in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation;

31 (4) Not apply any nonquantitative treatment limitations to benefits for behavioral, mental  
32 health, and substance use disorders that are not applied to medical and surgical benefits within

33 the same classification of benefits;

34 (5) Establish procedures to authorize treatment with a nonparticipating provider if a  
35 covered service is not available within established time and distance standards and within a  
36 reasonable period after service is requested, and with the same coinsurance, deductible, or  
37 copayment requirements as would apply if the service were provided at a participating provider,  
38 and at no greater cost to the covered person than if the services obtained at or from a participating  
39 provider;

40 (6) If a covered person obtains a covered service from a nonparticipating provider because  
41 the covered service is not available within the established time and distance standards, reimburse  
42 treatment or services for behavioral, mental health, or substance use disorders required to be  
43 covered pursuant to this subsection that are provided by a nonparticipating provider using the  
44 same methodology that the Public Employees Insurance Agency uses to reimburse covered  
45 medical services provided by nonparticipating providers and, upon request, provide evidence of  
46 the methodology to the person or provider.

47 (d) If the Public Employees Insurance Agency offers a plan that does not cover services  
48 provided by an out-of-network provider, it may provide the benefits required in subsection (c) if  
49 the services are rendered by a provider who is designated by and affiliated with the Public  
50 Employees Insurance Agency only if the same requirements apply for services for a physical  
51 illness;

52 (e) In the event of a concurrent review for a claim for coverage of services for the  
53 prevention of, screening for, and treatment of behavioral, mental health, and substance use  
54 disorders, the service continues to be a covered service until the Public Employees Insurance  
55 Agency notifies the covered person of the determination of the claim;

56 (f) Unless denied for nonpayment of premium, a denial of reimbursement for services for  
57 the prevention of, screening for, or treatment of behavioral, mental health, and substance use  
58 disorders by the Public Employees Insurance Agency must include the following language:

59 (1) A statement explaining that covered persons are protected under this section, which  
60 provides that limitations placed on the access to mental health and substance use disorder  
61 benefits may be no greater than any limitations placed on access to medical and surgical benefits;

62 (2) A statement providing information about the Consumer Services Division of the West  
63 Virginia Office of the Insurance Commissioner if the covered person believes his or her rights  
64 under this section have been violated; and

65 (3) A statement specifying that covered persons are entitled, upon request to the Public  
66 Employees Insurance Agency, to a copy of the medical necessity criteria for any behavioral,  
67 mental health, and substance use disorder benefit.

68 (g) On or after June 1, 2022 and annually thereafter, the Public Employees Insurance  
69 Agency shall submit a written report to the Joint Committee on Government and Finance that  
70 contains the following information regarding plans offered pursuant to this section:

71 (1) Data that demonstrates parity compliance for adverse determination regarding claims  
72 for behavioral, mental health, or substance use disorder services and includes the total number  
73 of adverse determinations for such claims;

74 (2) A description of the process used to develop and select:

75 (A) The medical necessity criteria used in determining benefits for behavioral health,  
76 mental health, and substance use disorders; and

77 (B) The medical necessity criteria used in determining medical and surgical benefits;

78 (3) Identification of all nonquantitative treatment limitations that are applied to benefits for  
79 behavioral, mental health, and substance use disorders and to medical and surgical benefits  
80 within each classification of benefits; and

81 (4) The results of analyses demonstrating that, for medical necessity criteria described in  
82 subsection (g)(2) of this section and for each nonquantitative treatment limitation identified in  
83 subsection (g)(3) of this section, as written and in operation, the processes, strategies, evidentiary  
84 standards, or other factors used in applying the medical necessity criteria and each

85 nonquantitative treatment limitation to benefits for behavioral, mental health, and substance use  
86 disorders within each classification of benefits are comparable to, and are applied no more  
87 stringently than, the processes, strategies, evidentiary standards, or other factors used in applying  
88 the medical necessity criteria and each nonquantitative treatment limitation to medical and  
89 surgical benefits within the corresponding classification of benefits.

90 (5) The Public Employees Insurance Agency's report of the analyses regarding  
91 nonquantitative treatment limitations shall include at a minimum:

92 (A) Identify factors used to determine whether a nonquantitative treatment limitation will  
93 apply to a benefit, including factors that were considered but rejected;

94 (B) Identify and define the specific evidentiary standards used to define the factors and  
95 any other evidence relied on in designing each nonquantitative treatment limitation;

96 (C) Provide the comparative analyses, including the results of the analyses, performed to  
97 determine that the processes and strategies used to design each nonquantitative treatment  
98 limitation, as written, and the written processes and strategies used to apply each nonquantitative  
99 treatment limitation for benefits for behavioral, mental health, and substance use disorders are  
100 comparable to, and are applied no more stringently than, the processes and strategies used to  
101 design and apply each nonquantitative treatment limitation, as written, and the written processes  
102 and strategies used to apply each nonquantitative treatment limitation for medical and surgical  
103 benefits;

104 (D) Provide the comparative analysis, including the results of the analyses, performed to  
105 determine that the processes and strategies used to apply each nonquantitative treatment  
106 limitation, in operation, for benefits for behavioral, mental health, and substance use disorders  
107 are comparable to, and are applied no more stringently than, the processes and strategies used  
108 to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits;  
109 and

110 (E) Disclose the specific findings and conclusions reached by the Public Employees

111 Insurance Agency that the results of the analyses indicate that each health benefit plan offered  
112 by the Public Employees Insurance Agency complies with subsection (c) and this section.

113 (h) The Public Employees Insurance Agency shall adopt legislative rules to comply with  
114 the provisions of this section. These rules or amendments to rules shall be proposed pursuant to  
115 the provisions of §29A-3-1 et seq. of this code within the applicable time limit to be considered by  
116 the Legislature during its regular session in the year 2022.

117 (i) This section is effective for policies, contracts, plans, or agreements, beginning on or  
118 after January 1, 2022. This section applies to all policies, contracts, plans, or agreements, subject  
119 to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
120 or after the effective date of this section.

## CHAPTER 33. INSURANCE.

### ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

#### §33-15-4x. Mental health parity.

1 (a) As used in this section, the following words and phrases have the meaning given them  
2 in this section unless the context clearly indicates otherwise:

3 “Behavioral, Mental Health and Substance Use Disorder” means a condition or disorder,  
4 regardless of etiology, that may be the result of a combination of genetic and environmental  
5 factors and that falls under any of the diagnostic categories listed in the mental disorders section  
6 of the most recent version of:

7 (1) The International Statistical Classification of Diseases and Related Health Problems;  
8 (2) The Diagnostic and Statistical Manual of Mental Disorders; or  
9 (3) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy  
10 and Early Childhood; and

11 Includes autism spectrum disorder.

12 (b) The Carrier is required to provide coverage for the prevention of, screening for and

13 treatment of behavioral, mental health and substance use disorders that is no less extensive than  
14 the coverage provided for any physical illness and that complies with the requirements of this  
15 section. This screening shall include, but is not limited to, unhealthy alcohol use for adults,  
16 substance use for adults and adolescents, and depression screening for adolescents and adults.

17 (c) The Carrier shall:

18 (1) Include coverage and reimbursement for behavioral health screenings using a  
19 validated screening tool for behavioral health, which coverage and reimbursement is no less  
20 extensive than the coverage and reimbursement for the annual physical examination.

21 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR  
22 146.136 (c)(4), or any successor regulation, regarding any limitations that are not expressed  
23 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to  
24 the limitations and examples listed in 45 CFR 146.136 (c)(4)(ii) and (c)(4)(iii), or any successor  
25 regulation and 78 FR 68246, include the methods by which the Carrier establishes and maintains  
26 its provider network and responds to deficiencies in the ability of its networks to provide timely  
27 access to care;

28 (3) Comply with the financial requirements and quantitative treatment limitations specified  
29 in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation;

30 (4) Not apply any nonquantitative treatment limitations to benefits for behavioral, mental  
31 health, and substance use disorders that are not applied to medical and surgical benefits within  
32 the same classification of benefits;

33 (5) Establish procedures to authorize treatment with a nonparticipating provider if a  
34 covered service is not available within established time and distance standards and within a  
35 reasonable period after service is requested, and with the same coinsurance, deductible, or  
36 copayment requirements as would apply if the service were provided at a participating provider,  
37 and at no greater cost to the covered person than if the services were obtained at or from a  
38 participating provider;



39 (6) If a covered person obtains a covered service from a nonparticipating provider because  
40 the covered service is not available within the established time and distance standards, reimburse  
41 treatment or services for behavioral, mental health, or substance use disorders required to be  
42 covered pursuant to this subsection that are provided by a nonparticipating provider using the  
43 same methodology that the Carrier uses to reimburse covered medical services provided by  
44 nonparticipating providers and, upon request, provide evidence of the methodology to the person  
45 or provider.

46 (d) If the Carrier offers a plan that does not cover services provided by an out-of-network  
47 provider, it may provide the benefits required in subsection (c) if the services are rendered by a  
48 provider who is designated by and affiliated with the Carrier only if the same requirements apply  
49 for services for a physical illness;

50 (e) In the event of a concurrent review for a claim for coverage of services for the  
51 prevention of, screening for, and treatment of behavioral, mental health, and substance use  
52 disorders, the service continues to be a covered service until the Carrier notifies the covered  
53 person of the determination of the claim;

54 (f) Unless denied for nonpayment of premium, a denial of reimbursement for services for  
55 the prevention of, screening for, or treatment of behavioral, mental health, and substance use  
56 disorders by the Carrier must include the following language:

57 (1) A statement explaining that covered persons are protected under this section, which  
58 provides that limitations placed on the access to mental health and substance use disorder  
59 benefits may be no greater than any limitations placed on access to medical and surgical benefits;

60 (2) A statement providing information about the Consumer Services Division of the West  
61 Virginia Office of the Insurance Commissioner if the covered person believes his or her rights  
62 under this section have been violated; and

63 (3) A statement specifying that covered persons are entitled, upon request to the Carrier,  
64 to a copy of the medical necessity criteria for any behavioral, mental health, and substance use

65 disorder benefit.

66 (g) On or after June 1, 2022, and annually thereafter, the Insurance Commissioner shall  
67 submit a written report to the Joint Committee on Government and Finance that contains the  
68 following information on plans which fall under this section regarding plans offered pursuant to  
69 this section:

70 (1) Data that demonstrates parity compliance for an adverse determination regarding  
71 claims for behavioral, mental health, or substance use disorder services and includes the total  
72 number of adverse determinations for such claims;

73 (2) A description of the process used to develop and select:

74 (A) The medical necessity criteria used in determining benefits for behavioral health,  
75 mental health, and substance use disorders; and

76 (B) The medical necessity criteria used in determining medical and surgical benefits;

77 (3) Identification of all nonquantitative treatment limitations that are applied to benefits for  
78 behavioral, mental health, and substance use disorders and to medical and surgical benefits  
79 within each classification of benefits; and

80 (4) The results of analyses demonstrating that, for medical necessity criteria described in  
81 subsection (g)(2) of this section and for each nonquantitative treatment limitation identified in  
82 subsection (g)(3) of this section, as written and in operation, the processes, strategies, evidentiary  
83 standards, or other factors used in applying the medical necessity criteria and each  
84 nonquantitative treatment limitation to benefits for behavioral, mental health, and substance use  
85 disorders within each classification of benefits are comparable to, and are applied no more  
86 stringently than, the processes, strategies, evidentiary standards, or other factors used in applying  
87 the medical necessity criteria and each nonquantitative treatment limitation to medical and  
88 surgical benefits within the corresponding classification of benefits.

89 (5) The Insurance Commissioner's report of the analyses regarding nonquantitative  
90 treatment limitations shall include at a minimum:

91 (A) Identify factors used to determine whether a nonquantitative treatment limitation will  
92 apply to a benefit, including factors that were considered but rejected;

93 (B) Identify and define the specific evidentiary standards used to define the factors and  
94 any other evidence relied on in designing each nonquantitative treatment limitation;

95 (C) Provide the comparative analyses, including the results of the analyses, performed to  
96 determine that the processes and strategies used to design each nonquantitative treatment  
97 limitation, as written, and the written processes and strategies used to apply each nonquantitative  
98 treatment limitation for benefits for behavioral, mental health, and substance use disorders are  
99 comparable to, and are applied no more stringently than, the processes and strategies used to  
100 design and apply each nonquantitative treatment limitation, as written, and the written processes  
101 and strategies used to apply each nonquantitative treatment limitation for medical and surgical  
102 benefits;

103 (D) Provide the comparative analysis, including the results of the analyses, performed to  
104 determine that the processes and strategies used to apply each nonquantitative treatment  
105 limitation, in operation, for benefits for behavioral, mental health, and substance use disorders  
106 are comparable to, and are applied no more stringently than, the processes and strategies used  
107 to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits;  
108 and

109 (E) Disclose the specific findings and conclusions reached by the Insurance  
110 Commissioner that the results of the analyses indicate that each health benefit plan offered under  
111 the provisions of this section complies with section (c) and this section.

112 (h) The Insurance Commission shall adopt legislative rules to comply with the provisions  
113 of this section. These rules or amendments to rules shall be proposed pursuant to the provisions  
114 of §29A-3-1 et seq. of this code within the applicable time limit to be considered by the Legislature  
115 during its regular session in the year 2022.

116 (i) This section is effective for policies, contracts, plans, or agreements, beginning on or

117 after January 1, 2022. This section applies to all policies, contracts, plans, or agreements, subject  
118 to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
119 or after the effective date of this section.

## **ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.**

### **§33-16-3ii. Mental health parity.**

1 (a) As used in this section, the following words and phrases have the meaning given them  
2 in this section unless the context clearly indicates otherwise:

3 “Behavioral, Mental Health and Substance Use Disorder” means a condition or disorder,  
4 regardless of etiology, that may be the result of a combination of genetic and environmental  
5 factors and that falls under any of the diagnostic categories listed in the mental disorders section  
6 of the most recent version of:

7 (1) The International Statistical Classification of Diseases and Related Health Problems;

8 (2) The Diagnostic and Statistical Manual of Mental Disorders; or

9 (3) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy  
10 and Early Childhood; and

11 Includes autism spectrum disorder.

12 (b) The Carrier is required to provide coverage for the prevention of, screening for and  
13 treatment of behavioral, mental health and substance use disorders that is no less extensive than  
14 the coverage provided for any physical illness and that complies with the requirements of this  
15 section. This screening shall include but is not limited to unhealthy alcohol use for adults,  
16 substance use for adults and adolescents, and depression screening for adolescents and adults.

17 (c) The Carrier shall:

18 (1) Include coverage and reimbursement for behavioral health screenings using a  
19 validated screening tool for behavioral health, which coverage and reimbursement is no less  
20 extensive than the coverage and reimbursement for the annual physical examination.

21 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR

22 146.136 (c)(4), or any successor regulation, regarding any limitations that are not expressed  
23 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to  
24 the limitations and examples listed in 45 CFR 146.136 (c)(4)(ii) and (c)(4)(iii), or any successor  
25 regulation and 78 FR 68246, include the methods by which the Carrier establishes and maintains  
26 its provider network and responds to deficiencies in the ability of its networks to provide timely  
27 access to care;

28 (3) Comply with the financial requirements and quantitative treatment limitations specified  
29 in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation;

30 (4) Not apply any nonquantitative treatment limitations to benefits for behavioral, mental  
31 health, and substance use disorders that are not applied to medical and surgical benefits within  
32 the same classification of benefits;

33 (5) Establish procedures to authorize treatment with a nonparticipating provider if a  
34 covered service is not available within established time and distance standards and within a  
35 reasonable period after service is requested, and with the same coinsurance, deductible, or  
36 copayment requirements as would apply if the service were provided at a participating provider,  
37 and at no greater cost to the covered person than if the services were obtain at or form a  
38 participating provider;

39 (6) If a covered person obtains a covered service from a nonparticipating provider because  
40 the covered service is not available within the established time and distance standards, reimburse  
41 treatment or services for behavioral, mental health, or substance use disorders required to be  
42 covered pursuant to this subsection that are provided by a nonparticipating provider using the  
43 same methodology that the Carrier uses to reimburse covered medical services provided by  
44 nonparticipating providers and, upon request, provide evidence of the methodology to the person  
45 or provider.

46 (d) If the Carrier offers a plan that does not cover services provided by an out-of-network  
47 provider, it may provide the benefits required in subsection (c) if the services are rendered by a

48 provider who is designated by and affiliated with the Carrier only if the same requirements apply  
49 for services for a physical illness;

50 (e) In the event of a concurrent review for a claim for coverage of services for the  
51 prevention of, screening for, and treatment of behavioral, mental health, and substance use  
52 disorders, the service continues to be a covered service until the Carrier notifies the covered  
53 person of the determination of the claim;

54 (f) Unless denied for nonpayment of premium, a denial of reimbursement for services for  
55 the prevention of, screening for, or treatment of behavioral, mental health, and substance use  
56 disorders by the Carrier must include the following language:

57 (1) A statement explaining that covered persons are protected under this section, which  
58 provides that limitations placed on the access to mental health and substance use disorder  
59 benefits may be no greater than any limitations placed on access to medical and surgical benefits;

60 (2) A statement providing information about the Consumer Services Division of the Office  
61 of the West Virginia Insurance Commissioner if the covered person believes his or her rights  
62 under this section have been violated; and

63 (3) A statement specifying that covered persons are entitled, upon request to the Carrier,  
64 to a copy of the medical necessity criteria for any behavioral, mental health, and substance use  
65 disorder benefit.

66 (g) On or after June 1, 2022, and annually thereafter, the Insurance Commissioner shall  
67 submit a written report to the Joint Committee on Government and Finance that contains the  
68 following information regarding plans offered pursuant to this section:

69 (1) Data that demonstrates parity compliance for an adverse determination regarding  
70 claims for behavioral, mental health, or substance use disorder services and includes the total  
71 number of adverse determinations for such claims;

72 (2) A description of the process used to develop and select:

73 (A) The medical necessity criteria used in determining benefits for behavioral health,

74 mental health, and substance use disorders; and

75 (B) The medical necessity criteria used in determining medical and surgical benefits;

76 (3) Identification of all nonquantitative treatment limitations that are applied to benefits for

77 behavioral, mental health, and substance use disorders and to medical and surgical benefits

78 within each classification of benefits; and

79 (4)The results of analyses demonstrating that, for medical necessity criteria described in

80 subsection (g)(2) of this section and for each nonquantitative treatment limitation identified in

81 subsection (g)(3) of this section, as written and in operation, the processes, strategies, evidentiary

82 standards, or other factors used in applying the medical necessity criteria and each

83 nonquantitative treatment limitation to benefits for behavioral, mental health, and substance use

84 disorders within each classification of benefits are comparable to, and are applied no more

85 stringently than, the processes, strategies, evidentiary standards, or other factors used in applying

86 the medical necessity criteria and each nonquantitative treatment limitation to medical and

87 surgical benefits within the corresponding classification of benefits.

88 (5) The Insurance Commissioner's report of the analyses regarding nonquantitative

89 treatment limitations shall include at a minimum:

90 (A) Identify factors used to determine whether a nonquantitative treatment limitation will

91 apply to a benefit, including factors that were considered but rejected;

92 (B) Identify and define the specific evidentiary standards used to define the factors and

93 any other evidence relied on in designing each nonquantitative treatment limitation;

94 (C) Provide the comparative analyses, including the results of the analyses, performed to

95 determine that the processes and strategies used to design each nonquantitative treatment

96 limitation, as written, and the written processes and strategies used to apply each nonquantitative

97 treatment limitation for benefits for behavioral, mental health, and substance use disorders are

98 comparable to, and are applied no more stringently than, the processes and strategies used to

99 design and apply each nonquantitative treatment limitation, as written, and the written processes

100 and strategies used to apply each nonquantitative treatment limitation for medical and surgical  
101 benefits;

102 (D) Provide the comparative analysis, including the results of the analyses, performed to  
103 determine that the processes and strategies used to apply each nonquantitative treatment  
104 limitation, in operation, for benefits for behavioral, mental health, and substance use disorders  
105 are comparable to, and are applied no more stringently than, the processes and strategies used  
106 to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits;  
107 and

108 (E) Disclose the specific findings and conclusions reached by the Insurance  
109 Commissioner that the results of the analyses indicate that each health benefit plan which falls  
110 under the provisions of this section complies with section (c) and this section.

111 (h) The Insurance Commission shall adopt legislative rules to comply with the provisions  
112 of this section. These rules or amendments to rules shall be proposed pursuant to the provisions  
113 of §29A-3-1 et seq. of this code within the applicable time limit to be considered by the Legislature  
114 during its regular session in the year 2022.

115 (i) This section is effective for policies, contracts, plans, or agreements, beginning on or  
116 after January 1, 2022. This section applies to all policies, contracts, plans, or agreements, subject  
117 to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
118 or after the effective date of this section.

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

**§33-24-7x. Mental Health Parity.**

1 (a) As used in this section, the following words and phrases have the meaning given them  
2 in this section unless the context clearly indicates otherwise:



3 “Behavioral, Mental Health and Substance Use Disorder” means a condition or disorder,  
4 regardless of etiology, that may be the result of a combination of genetic and environmental  
5 factors and that falls under any of the diagnostic categories listed in the mental disorders section  
6 of the most recent version of:

7 (1) The International Statistical Classification of Diseases and Related Health Problems;  
8 (2) The Diagnostic and Statistical Manual of Mental Disorders; or  
9 (3) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy  
10 and Early Childhood; and  
11 Includes autism spectrum disorder.

12 (b) The Carrier is required to provide coverage for the prevention of, screening for and  
13 treatment of behavioral, mental health and substance use disorders that is no less extensive than  
14 the coverage provided for any physical illness and that complies with the requirements of this  
15 section. This screening shall include, but is not limited to, unhealthy alcohol use for adults,  
16 substance use for adults and adolescents, and depression screening for adolescents and adults.

17 (c) The Carrier shall:

18 (1) Include coverage and reimbursement for behavioral health screenings using a  
19 validated screening tool for behavioral health, which coverage and reimbursement is no less  
20 extensive than the coverage and reimbursement for the annual physical examination.

21 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR  
22 146.136 (c)(4), or any successor regulation, regarding any limitations that are not expressed  
23 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to  
24 the limitations and examples listed in 45 CFR 146.136 (c)(4)(ii) and (c)(4)(iii), or any successor  
25 regulation and 78 FR 68246, include the methods by which the Carrier establishes and maintains  
26 its provider network and responds to deficiencies in the ability of its networks to provide timely  
27 access to care;

28 (3) Comply with the financial requirements and quantitative treatment limitations specified

29 in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation;

30 (4) Not apply any nonquantitative treatment limitations to benefits for behavioral, mental  
31 health, and substance use disorders that are not applied to medical and surgical benefits within  
32 the same classification of benefits;

33 (5) Establish procedures to authorize treatment with a nonparticipating provider if a  
34 covered service is not available within established time and distance standards and within a  
35 reasonable period after service is requested, and with the same coinsurance, deductible, or  
36 copayment requirements as would apply if the service were provided at a participating provider,  
37 and at no greater cost to the covered person than if the services were obtained at or from a  
38 participating provider;

39 (6) If a covered person obtains a covered service from a nonparticipating provider because  
40 the covered service is not available within the established time and distance standards, reimburse  
41 treatment or services for behavioral, mental health, or substance use disorders required to be  
42 covered pursuant to this subsection that are provided by a nonparticipating provider using the  
43 same methodology that the Carrier uses to reimburse covered medical services provided by  
44 nonparticipating providers and, upon request, provide evidence of the methodology to the person  
45 or provider.

46 (d) If the Carrier offers a plan that does not cover services provided by an out-of-network  
47 provider, it may provide the benefits required in subsection (c) if the services are rendered by a  
48 provider who is designated by and affiliated with the Carrier only if the same requirements apply  
49 for services for a physical illness;

50 (e) In the event of a concurrent review for a claim for coverage of services for the  
51 prevention of, screening for, and treatment of behavioral, mental health, and substance use  
52 disorders, the service continues to be a covered service until the Carrier notifies the covered  
53 person of the determination of the claim;

54 (f) Unless denied for nonpayment of premium, a denial of reimbursement for services for

55 the prevention of, screening for, or treatment of behavioral, mental health, and substance use  
56 disorders by the Carrier must include the following language:

57 (1) A statement explaining that covered persons are protected under this section, which  
58 provides that limitations placed on the access to mental health and substance use disorder  
59 benefits may be no greater than any limitations placed on access to medical and surgical benefits;

60 (2) A statement providing information about the Consumer Services Division of the Office  
61 of the West Virginia Insurance Commissioner if the covered person believes his or her rights  
62 under this section have been violated; and

63 (3) A statement specifying that covered persons are entitled, upon request to the Carrier,  
64 to a copy of the medical necessity criteria for any behavioral, mental health, and substance use  
65 disorder benefit.

66 (g) On or after June 1, 2022, and annually thereafter, the Insurance Commissioner shall  
67 submit a written report to the Joint Committee on Government and Finance that contains the  
68 following information regarding plans offered pursuant to this section:

69 (1) Data that demonstrates parity compliance for an adverse determination regarding  
70 claims for behavioral, mental health, or substance use disorder services and includes the total  
71 number of adverse determinations for such claims;

72 (2) A description of the process used to develop and select:

73 (A) The medical necessity criteria used in determining benefits for behavioral health,  
74 mental health, and substance use disorders; and

75 (B) The medical necessity criteria used in determining medical and surgical benefits;

76 (3) Identification of all nonquantitative treatment limitations that are applied to benefits for  
77 behavioral, mental health, and substance use disorders and to medical and surgical benefits  
78 within each classification of benefits; and

79 (4) The results of analyses demonstrating that, for medical necessity criteria described in  
80 subsection (g)(2) of this section and for each nonquantitative treatment limitation identified in

81 subsection (g)(3) of this section, as written and in operation, the processes, strategies, evidentiary  
82 standards, or other factors used in applying the medical necessity criteria and each  
83 nonquantitative treatment limitation to benefits for behavioral, mental health, and substance use  
84 disorders within each classification of benefits are comparable to, and are applied no more  
85 stringently than, the processes, strategies, evidentiary standards, or other factors used in applying  
86 the medical necessity criteria and each nonquantitative treatment limitation to medical and  
87 surgical benefits within the corresponding classification of benefits.

88 (5) The Insurance Commissioner's report of the analyses regarding nonquantitative  
89 treatment limitations shall include at a minimum:

90 (A) Identify factors used to determine whether a nonquantitative treatment limitation will  
91 apply to a benefit, including factors that were considered but rejected;

92 (B) Identify and define the specific evidentiary standards used to define the factors and  
93 any other evidence relied on in designing each nonquantitative treatment limitation;

94 (C) Provide the comparative analyses, including the results of the analyses, performed to  
95 determine that the processes and strategies used to design each nonquantitative treatment  
96 limitation, as written, and the written processes and strategies used to apply each nonquantitative  
97 treatment limitation for benefits for behavioral, mental health, and substance use disorders are  
98 comparable to, and are applied no more stringently than, the processes and strategies used to  
99 design and apply each nonquantitative treatment limitation, as written, and the written processes  
100 and strategies used to apply each nonquantitative treatment limitation for medical and surgical  
101 benefits;

102 (D) Provide the comparative analysis, including the results of the analyses, performed to  
103 determine that the processes and strategies used to apply each nonquantitative treatment  
104 limitation, in operation, for benefits for behavioral, mental health, and substance use disorders  
105 are comparable to, and are applied no more stringently than, the processes and strategies used  
106 to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits;

107 and

108 (E) Disclose the specific findings and conclusions reached by the Insurance  
109 Commissioner that the results of the analyses indicate that each health benefit plan offered  
110 pursuant to this section complies with section (c) and this section.

111 (h) The Insurance Commission shall adopt legislative rules to comply with the provisions  
112 of this section. These rules or amendments to rules shall be proposed pursuant to the provisions  
113 of §29A-3-1 et seq. of this code within the applicable time limit to be considered by the Legislature  
114 during its regular session in the year 2022.

115 (i) This section is effective for policies, contracts, plans or agreements, beginning on or  
116 after January 1, 2022. This section applies to all policies, contracts, plans, or agreements, subject  
117 to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
118 or after the effective date of this section.

## **ARTICLE 25. HEALTH CARE CORPORATIONS.**

### **§33-25-8u. Mental health parity.**

1 (a) As used in this section, the following words and phrases have the meaning given them  
2 in this section unless the context clearly indicates otherwise:

3 “Behavioral, Mental Health and Substance Use Disorder” means a condition or disorder,  
4 regardless of etiology, that may be the result of a combination of genetic and environmental  
5 factors and that falls under any of the diagnostic categories listed in the mental disorders section  
6 of the most recent version of:

7 (1) The International Statistical Classification of Diseases and Related Health Problems;

8 (2) The Diagnostic and Statistical Manual of Mental Disorders; or

9 (3) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy  
10 and Early Childhood; and

11 Includes autism spectrum disorder.

12 (b) The Carrier is required to provide coverage for the prevention of, screening for and

13 treatment of behavioral, mental health and substance use disorders that is no less extensive than  
14 the coverage provided for any physical illness and that complies with the requirements of this  
15 section. This screening shall include, but is not limited to, unhealthy alcohol use for adults,  
16 substance use for adults and adolescents, and depression screening for adolescents and adults.

17 (c) The Carrier shall:

18 (1) Include coverage and reimbursement for behavioral health screenings using a  
19 validated screening tool for behavioral health, which coverage and reimbursement is no less  
20 extensive than the coverage and reimbursement for the annual physical examination.

21 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR  
22 146.136 (c)(4), or any successor regulation, regarding any limitations that are not expressed  
23 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to  
24 the limitations and examples listed in 45 CFR 146.136 (c)(4)(ii) and (c)(4)(iii), or any successor  
25 regulation and 78 FR 68246, include the methods by which the Carrier establishes and maintains  
26 its provider network and responds to deficiencies in the ability of its networks to provide timely  
27 access to care;

28 (3) Comply with the financial requirements and quantitative treatment limitations specified  
29 in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation;

30 (4) Not apply any nonquantitative treatment limitations to benefits for behavioral, mental  
31 health, and substance use disorders that are not applied to medical and surgical benefits within  
32 the same classification of benefits;

33 (5) Establish procedures to authorize treatment with a nonparticipating provider if a  
34 covered service is not available within established time and distance standards and within a  
35 reasonable period after service is requested, and with the same coinsurance, deductible, or  
36 copayment requirements as would apply if the service were provided at a participating provider,  
37 and at no greater cost to the covered person than if the services were obtained at or from a  
38 participating provider;

39 (6) If a covered person obtains a covered service from a nonparticipating provider because  
40 the covered service is not available within the established time and distance standards, reimburse  
41 treatment or services for behavioral, mental health, or substance use disorders required to be  
42 covered pursuant to this subsection that are provided by a nonparticipating provider using the  
43 same methodology that the Carrier uses to reimburse covered medical services provided by  
44 nonparticipating providers and, upon request, provide evidence of the methodology to the person  
45 or provider.

46 (d) If the Carrier offers a plan that does not cover services provided by an out-of-network  
47 provider, it may provide the benefits required in subsection (c) if the services are rendered by a  
48 provider who is designated by and affiliated with the Carrier only if the same requirements apply  
49 for services for a physical illness;

50 (e) In the event of a concurrent review for a claim for coverage of services for the  
51 prevention of, screening for, and treatment of behavioral, mental health, and substance use  
52 disorders, the service continues to be a covered service until the Carrier notifies the covered  
53 person of the determination of the claim;

54 (f) Unless denied for nonpayment of premium, a denial of reimbursement for services for  
55 the prevention of, screening for, or treatment of behavioral, mental health, and substance use  
56 disorders by the Carrier must include the following language:

57 (1) A statement explaining that covered persons are protected under this section, which  
58 provides that limitations placed on the access to mental health and substance use disorder  
59 benefits may be no greater than any limitations placed on access to medical and surgical benefits;

60 (2) A statement providing information about the Consumer Services Division of the Office  
61 of the West Virginia Insurance Commissioner if the covered person believes his or her rights  
62 under this section have been violated; and

63 (3) A statement specifying that covered persons are entitled, upon request to the Carrier,  
64 to a copy of the medical necessity criteria for any behavioral, mental health, and substance use

65 disorder benefit.

66 (g) On or after June 1, 2022, and annually thereafter, the Insurance Commissioner shall  
67 submit a written report to the Joint Committee on Government and Finance that contains the  
68 following information regarding plans offered pursuant to this section:

69 (1) Data that demonstrates parity compliance for an adverse determination regarding  
70 claims for behavioral, mental health, or substance use disorder services and includes the total  
71 number of adverse determinations for such claims;

72 (2) A description of the process used to develop and select:

73 (A) The medical necessity criteria used in determining benefits for behavioral health,  
74 mental health, substance use disorders; and

75 (B) The medical necessity criteria used in determining medical and surgical benefits;

76 (3) Identification of all nonquantitative treatment limitations that are applied to benefits for  
77 behavioral, mental health, and substance use disorders and to medical and surgical benefits  
78 within each classification of benefits; and

79 (4)The results of analyses demonstrating that, for medical necessity criteria described in  
80 subsection (g)(2) of this section and for each nonquantitative treatment limitation identified in  
81 subsection (g)(3) of this section, as written and in operation, the processes, strategies, evidentiary  
82 standards, or other factors used in applying the medical necessity criteria and each  
83 nonquantitative treatment limitation to benefits for behavioral, mental health, and substance use  
84 disorders within each classification of benefits are comparable to, and are applied no more  
85 stringently than, the processes, strategies, evidentiary standards, or other factors used in applying  
86 the medical necessity criteria and each nonquantitative treatment limitation to medical and  
87 surgical benefits within the corresponding classification of benefits.

88 (5) The Insurance Commissioner's report of the analyses regarding nonquantitative  
89 treatment limitations shall include at a minimum:

90 (A) Identify factors used to determine whether a nonquantitative treatment limitation will



91 apply to a benefit, including factors that were considered but rejected;

92 (B) Identify and define the specific evidentiary standards used to define the factors and  
93 any other evidence relied on in designing each nonquantitative treatment limitation;

94 (C) Provide the comparative analyses, including the results of the analyses, performed to  
95 determine that the processes and strategies used to design each nonquantitative treatment  
96 limitation, as written, and the written processes and strategies used to apply each nonquantitative  
97 treatment limitation for benefits for behavioral, mental health, and substance use disorders are  
98 comparable to, and are applied no more stringently than, the processes and strategies used to  
99 design and apply each nonquantitative treatment limitation, as written, and the written processes  
100 and strategies used to apply each nonquantitative treatment limitation for medical and surgical  
101 benefits;

102 (D) Provide the comparative analysis, including the results of the analyses, performed to  
103 determine that the processes and strategies used to apply each nonquantitative treatment  
104 limitation, in operation, for benefits for behavioral, mental health, and substance use disorders  
105 are comparable to, and are applied no more stringently than, the processes and strategies used  
106 to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits;  
107 and

108 (E) Disclose the specific findings and conclusions reached by the Insurance Commission  
109 that the results of the analyses indicate that each health benefit plan offered pursuant to this  
110 section complies with section (c) and this section.

111 (h) The Insurance Commission shall adopt legislative rules to comply with the provisions  
112 of this section. These rules or amendments to rules shall be proposed pursuant to the provisions  
113 of §29A-3-1 et seq. of this code within the applicable time limit to be considered by the Legislature  
114 during its regular session in the year 2022.

115 (i) This section is effective for policies, contracts, plans or agreements, beginning on or  
116 after January 1, 2022. This section applies to all policies, contracts, plans, or agreements, subject

117 to this article that are delivered, executed, issues, amended, adjusted, or renewed in this state on  
118 or after the effective date of this section.

## **ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.**

### **§33-25A-8x. Mental health parity.**

1 (a) As used in this section, the following words and phrases have the meaning given them  
2 in this section unless the context clearly indicates otherwise:

3 “Behavioral, Mental Health and Substance Use Disorder” means a condition or disorder,  
4 regardless of etiology, that may be the result of a combination of genetic and environmental  
5 factors and that falls under any of the diagnostic categories listed in the mental disorders section  
6 of the most recent version of:

7 (1) The International Statistical Classification of Diseases and Related Health Problems;

8 (2) The Diagnostic and Statistical Manual of Mental Disorders; or

9 (3) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy  
10 and Early Childhood; and

11 Includes autism spectrum disorder.

12 (b) The Carrier is required to provide coverage for the prevention of, screening for and  
13 treatment of behavioral, mental health and substance use disorders that is no less extensive than  
14 the coverage provided for any physical illness and that complies with the requirements of this  
15 section. This screening shall include, but is not limited to, unhealthy alcohol use for adults,  
16 substance use for adults and adolescents, and depression screening for adolescents and adults.

17 (c) The Carrier shall:

18 (1) Include coverage and reimbursement for behavioral health screenings using a  
19 validated screening tool for behavioral health, which coverage and reimbursement is no less  
20 extensive than the coverage and reimbursement for the annual physical examination.

21 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR  
22 146.136 (c)(4), or any successor regulation, regarding any limitations that are not expressed

23 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to  
24 the limitations and examples listed in 45 CFR 146.136 (c)(4)(ii) and (c)(4)(iii), or any successor  
25 regulation and 78 FR 68246, include the methods by which the Carrier establishes and maintains  
26 its provider network and responds to deficiencies in the ability of its networks to provide timely  
27 access to care;

28 (3) Comply with the financial requirements and quantitative treatment limitations specified  
29 in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation;

30 (4) Not apply any nonquantitative treatment limitations to benefits for behavioral, mental  
31 health, and substance use disorders that are not applied to medical and surgical benefits within  
32 the same classification of benefits;

33 (5) Establish procedures to authorize treatment with a nonparticipating provider if a  
34 covered service is not available within established time and distance standards and within a  
35 reasonable period after service is requested, and with the same coinsurance, deductible, or  
36 copayment requirements as would apply if the service were provided at a participating provider,  
37 and at no greater cost to the covered person than if the services were obtained at or from a  
38 participating provider;

39 (6) If a covered person obtains a covered service from a nonparticipating provider because  
40 the covered service is not available within the established time and distance standards, reimburse  
41 treatment or services for behavioral, mental health, or substance use disorders required to be  
42 covered pursuant to this subsection that are provided by a nonparticipating provider using the  
43 same methodology that the Carrier uses to reimburse covered medical services provided by  
44 nonparticipating providers and, upon request, provide evidence of the methodology to the person  
45 or provider.

46 (d) If the Carrier offers a plan that does not cover services provided by an out-of-network  
47 provider, it may provide the benefits required in subsection (c) if the services are rendered by a  
48 provider who is designated by and affiliated with the Carrier only if the same requirements apply

49 for services for a physical illness;

50 (e) In the event of a concurrent review for a claim for coverage of services for the  
51 prevention of, screening for, and treatment of behavioral, mental health, and substance use  
52 disorders, the service continues to be a covered service until the Carrier notifies the covered  
53 person of the determination of the claim;

54 (f) Unless denied for nonpayment of premium, a denial of reimbursement for services for  
55 the prevention of, screening for, or treatment of behavioral, mental health, and substance use  
56 disorders by the Carrier must include the following language:

57 (1) A statement explaining that covered persons are protected under this section, which  
58 provides that limitations placed on the access to mental health and substance use disorder  
59 benefits may be no greater than any limitations placed on access to medical and surgical benefits;

60 (2) A statement providing information about the Division of Consumer Services of the  
61 Office of the West Virginia Insurance Commissioner if the covered person believes his or her  
62 rights under this section have been violated; and

63 (3) A statement specifying that covered persons are entitled, upon request to the Carrier,  
64 to a copy of the medical necessity criteria for any behavioral, mental health, and substance use  
65 disorder benefit.

66 (g) On or after June 1, 2022, and annually thereafter, the Insurance Commissioner shall  
67 submit a written report to the Joint Committee on Government and Finance that contains the  
68 following information regarding plans offered pursuant to this section:

69 (1) Data that demonstrates parity compliance for an adverse determination regarding  
70 claims for behavioral, mental health, or substance use disorder services and includes the total  
71 number of adverse determinations for such claims;

72 (2) A description of the process used to develop and select:

73 (A) The medical necessity criteria used in determining benefits for behavioral health,  
74 mental health, and substance use disorders; and

75 (B) The medical necessity criteria used in determining medical and surgical benefits;

76 (3) Identification of all nonquantitative treatment limitations that are applied to benefits for  
77 behavioral, mental health, and substance use disorders and to medical and surgical benefits  
78 within each classification of benefits; and

79 (4)The results of analyses demonstrating that, for medical necessity criteria described in  
80 subsection (g)(2) of this section and for each nonquantitative treatment limitation identified in  
81 subsection (g)(3) of this section, as written and in operation, the processes, strategies, evidentiary  
82 standards, or other factors used in applying the medical necessity criteria and each  
83 nonquantitative treatment limitation to benefits for behavioral, mental health, and substance use  
84 disorders within each classification of benefits are comparable to, and are applied no more  
85 stringently than, the processes, strategies, evidentiary standards, or other factors used in applying  
86 the medical necessity criteria and each nonquantitative treatment limitation to medical and  
87 surgical benefits within the corresponding classification of benefits.

88 (5) The Insurance Commission's report of the analyses regarding nonquantitative  
89 treatment limitations shall include at a minimum:

90 (A) Identify factors used to determine whether a nonquantitative treatment limitation will  
91 apply to a benefit, including factors that were considered but rejected;

92 (B) Identify and define the specific evidentiary standards used to define the factors and  
93 any other evidence relied on in designing each nonquantitative treatment limitation;

94 (C) Provide the comparative analyses, including the results of the analyses, performed to  
95 determine that the processes and strategies used to design each nonquantitative treatment  
96 limitation, as written, and the written processes and strategies used to apply each nonquantitative  
97 treatment limitation for benefits for behavioral, mental health, and substance use disorders are  
98 comparable to, and are applied no more stringently than, the processes and strategies used to  
99 design and apply each nonquantitative treatment limitation, as written, and the written processes  
100 and strategies used to apply each nonquantitative treatment limitation for medical and surgical

101 benefits;

102 (D) Provide the comparative analysis, including the results of the analyses, performed to  
103 determine that the processes and strategies used to apply each nonquantitative treatment  
104 limitation, in operation, for benefits for behavioral, mental health, and substance use disorders  
105 are comparable to, and are applied no more stringently than, the processes and strategies used  
106 to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits;  
107 and

108 (E) Disclose the specific findings and conclusions reached by the Insurance  
109 Commissioner that the results of the analyses indicate that each health benefit plan offered  
110 pursuant to this section complies with section (c) and this section.

111 (h) The Insurance Commission shall adopt legislative rules to comply with the provisions  
112 of this section. These rules or amendments to rules shall be proposed pursuant to the provisions  
113 of §29A-3-1 et seq. of this code within the applicable time limit to be considered by the Legislature  
114 during its regular session in the year 2022.

115 (i) This section is effective for policies, contracts, plans, or agreements, beginning on or  
116 after January 1, 2022. This section applies to all policies, contracts, plans, or agreements, subject  
117 to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
118 or after the effective date of this section.

NOTE: The purpose of this bill is to require the Public Employees Insurance Agency and other health insurance providers provide mental health parity between behavioral health, mental health, substance use disorders, and medical and surgical procedures.

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