WEST VIRGINIA LEGISLATURE

2024 REGULAR SESSION

Introduced

Senate Bill 228

By Senators Woodrum, Chapman, Rucker, and

Deeds

[Introduced January 11, 2024; referred

to the Committee on Health and Human Resources;

and then to the Committee on Finance]

A BILL to amend and reenact §5-16-7 of the Code of West Virginia, 1931, as amended; to amend said code by adding thereto a new section, designated §9-5-34; to amend said code by adding thereto a new section, designated §33-15-4x; to amend said code by adding thereto a new section, designated §33-16-3rr; to amend said code by adding thereto a new section, designated §33-24-7y; to amend said code by adding thereto a new section, designated §33-25-8v; and to amend said code by adding thereto a new section, designated §33-25A-8y, all relating to requiring medically necessary care and treatment to address congenital anomalies associated with cleft lip and cleft palate; setting forth eligibility age; required coverage; exclusions; coverage terms; and effective 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.

§5-16-7. Authorization to establish plans; mandated benefits; optional plans; separate rating for claims experience purposes.

(a) The agency shall establish plans for those employees herein made eligible and establish and promulgate rules for the administration of these plans subject to the limitations contained in this article. These plans shall include:

(1) Coverages and benefits for x-ray and laboratory services in connection with mammograms when medically appropriate and consistent with current guidelines from the United States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from either the

United States Preventive Services Task Force or the American College of Obstetricians and Gynecologists; and a test for the human papilloma virus when medically appropriate and consistent with current guidelines from either the United States Preventive Services Task Force or the American College of Obstetricians and Gynecologists, when performed for cancer screening or diagnostic services on a woman age 18 or over;

(2) Annual checkups for prostate cancer in men age 50 and over;

(3) Annual screening for kidney disease as determined to be medically necessary by a physician using any combination of blood pressure testing, urine albumin or urine protein testing, and serum creatinine testing as recommended by the National Kidney Foundation;

(4) For plans that include maternity benefits, coverage for inpatient care in a duly licensed health care facility for a mother and her newly born infant for the length of time which the attending physician considers medically necessary for the mother or her newly born child. No plan may deny payment for a mother or her newborn child prior to 48 hours following a vaginal delivery or prior to 96 hours following a caesarean section delivery if the attending physician considers discharge medically inappropriate;

(5) For plans which provide coverages for post-delivery care to a mother and her newly born child in the home, coverage for inpatient care following childbirth as provided in subdivision (4) of this subsection if inpatient care is determined to be medically necessary by the attending physician. These plans may include, among other things, medicines, medical equipment, prosthetic appliances, and any other inpatient and outpatient services and expenses considered appropriate and desirable by the agency; and

(6) Coverage for treatment of serious mental illness:

(A) The coverage does not include custodial care, residential care, or schooling. For purposes of this section, "serious mental illness" means an illness included in the American Psychiatric Association’s diagnostic and statistical manual of mental disorders, as periodically revised, under the diagnostic categories or subclassifications of:

(i) Schizophrenia and other psychotic disorders;

(ii) Bipolar disorders;

(iii) Depressive disorders;

(iv) Substance-related disorders with the exception of caffeine-related disorders and nicotine-related disorders;

(v) Anxiety disorders; and

(vi) Anorexia and bulimia.

With regard to a covered individual who has not yet attained the age of 19 years, "serious mental illness" also includes attention deficit hyperactivity disorder, separation anxiety disorder, and conduct disorder.

(B) The agency shall not discriminate between medical-surgical benefits and mental health benefits in the administration of its plan. With regard to both medical-surgical and mental health benefits, it may make determinations of medical necessity and appropriateness and it may use recognized health care quality and cost management tools including, but not limited to, limitations on inpatient and outpatient benefits, utilization review, implementation of cost-containment measures, preauthorization for certain treatments, setting coverage levels, setting maximum number of visits within certain time periods, using capitated benefit arrangements, using fee-for-service arrangements, using third-party administrators, using provider networks, and using patient cost sharing in the form of copayments, deductibles, and coinsurance. Additionally, the agency shall comply with the financial requirements and quantitative treatment limitations specified in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation. The agency may not apply any nonquantitative treatment limitations to benefits for behavioral health, mental health, and substance use disorders that are not applied to medical and surgical benefits within the same classification of benefits: *Provided*, That any service, even if it is related to the behavioral health, mental health, or substance use diagnosis if medical in nature, shall be reviewed as a medical claim and undergo all utilization review as applicable;

(7) Coverage for general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care if the covered person is:

(A) Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the individual and for whom a superior result can be expected from dental care provided under general anesthesia.

(B) A child who is 12 years of age or younger with documented phobias or with documented mental illness and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth, or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

(8) (A) All plans shall include coverage for diagnosis, evaluation, and treatment of autism spectrum disorder in individuals ages 18 months to 18 years. To be eligible for coverage and benefits under this subdivision, the individual must be diagnosed with autism spectrum disorder at age eight or younger. Such plan shall provide coverage for treatments that are medically necessary and ordered or prescribed by a licensed physician or licensed psychologist and in accordance with a treatment plan developed from a comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism spectrum disorder.

(B) The coverage shall include, but not be limited to, applied behavior analysis which shall be provided or supervised by a certified behavior analyst. This subdivision does not limit, replace, or affect any obligation to provide services to an individual under the Individuals with Disabilities Education Act, 20 U. S. C. §1400 *et seq*., as amended from time to time, or other publicly funded programs. Nothing in this subdivision requires reimbursement for services provided by public school personnel.

(C) The certified behavior analyst shall file progress reports with the agency semiannually. In order for treatment to continue, the agency must receive objective evidence or a clinically supportable statement of expectation that:

(i) The individual's condition is improving in response to treatment;

(ii) A maximum improvement is yet to be attained; and

(iii) There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

(D) To the extent that the provisions of this subdivision require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of insurance plans offered by the Public Employees Insurance Agency.

(9) For plans that include maternity benefits, coverage for the same maternity benefits for all individuals participating in or receiving coverage under plans that are issued or renewed on or after January 1, 2014: *Provided*, That to the extent that the provisions of this subdivision require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of a health benefit plan when the plan is offered in this state.

(10) (A) Coverage, through the age of 20, for amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state pursuant to either §30-3-1 *et seq*. or §30-14-1 *et seq*. of this code:

(i) Immunoglobulin E and nonimmunoglobulin E-medicated allergies to multiple food proteins;

(ii) Severe food protein-induced enterocolitis syndrome;

(iii) Eosinophilic disorders as evidenced by the results of a biopsy; and

(iv) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract (short bowel).

(B) The coverage required by paragraph (A) of this subdivision shall include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary, regardless of methodology of delivery.

(C) For purposes of this subdivision, "medically necessary foods" or "medical foods" shall mean prescription amino acid-based elemental formulas obtained through a pharmacy: *Provided*, That these foods are specifically designated and manufactured for the treatment of severe allergic conditions or short bowel.

(D) The provisions of this subdivision shall not apply to persons with an intolerance for lactose or soy.

(11) The cost for coverage of children's immunization services from birth through age 16 years to provide immunization against the following illnesses: Diphtheria, polio, mumps, measles, rubella, tetanus, hepatitis-b, hemophilia influenzae-b, and whooping cough. Any contract entered into to cover these services shall require that all costs associated with immunization, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration be exempt from any deductible, per visit charge, and copayment provisions which may be in force in these policies or contracts. This section does not require that other health care services provided at the time of immunization be exempt from any deductible or copayment provisions.

(12) The provision requiring coverage for 12-month refill for contraceptive drugs codified at §33-58-1 of this code.

(13) The group life and accidental death insurance herein provided shall be in the amount of $10,000 for every employee.

(b) The agency shall make available to each eligible employee, at full cost to the employee,

the opportunity to purchase optional group life and accidental death insurance as established under the rules of the agency. In addition, each employee is entitled to have his or her spouse and dependents, as defined by the rules of the agency, included in the optional coverage, at full cost to the employee, for each eligible dependent.

(c) The finance board may cause to be separately rated for claims experience purposes:

(1) All employees of the State of West Virginia;

(2) All teaching and professional employees of state public institutions of higher education and county boards of education;

(3) All nonteaching employees of the Higher Education Policy Commission, West Virginia Council for Community and Technical College Education, and county boards of education; or

(4) Any other categorization which would ensure the stability of the overall program.

(d) The agency shall maintain the medical and prescription drug coverage for Medicare-eligible retirees by providing coverage through one of the existing plans or by enrolling the Medicare-eligible retired employees into a Medicare-specific plan, including, but not limited to, the Medicare/Advantage Prescription Drug Plan. If a Medicare-specific plan is no longer available or advantageous for the agency and the retirees, the retirees remain eligible for coverage through the agency.

(e) The agency shall establish procedures to authorize treatment with a nonparticipating provider if a covered service is not available within established time and distance standards and within a reasonable period after service is requested, and with the same coinsurance, deductible, or copayment requirements as would apply if the service were provided at a participating provider, and at no greater cost to the covered person than if the services were obtained at or from a participating provider.

(f) If the Public Employees Insurance Agency offers a plan that does not cover services provided by an out-of-network provider, it may provide the benefits required in paragraph (A), subdivision (6), subsection (a) of this section if the services are rendered by a provider who is

designated by and affiliated with the Public Employees Insurance Agency, and only if the same requirements apply for services for a physical illness.

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

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

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

(2) A statement providing information about the internal appeals process if the covered person believes his or her rights under this section have been violated; and

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

(i) On or after June 1, 2021, and annually thereafter, the Public Employees Insurance Agency shall submit a written report to the Joint Committee on Government and Finance that contains the following information regarding plans offered pursuant to this section:

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

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

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

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

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

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

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

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

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

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

benefits;

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

(E) Disclose the specific findings and conclusions reached by the Public Employees Insurance Agency that the results of the analyses indicate that each health benefit plan offered by the Public Employees Insurance Agency complies with paragraph (B), subdivision (6), subsection (a) of this section; and

(6) After the initial report required by this subsection, annual reports are only required for any year thereafter during which the Public Employees Insurance Agency makes significant changes to how it designs and applies medical management protocols.

(j) The Public Employees Insurance Agency shall update its annual plan document to reflect its comprehensive parity compliance. An annual report shall also be filed with the Joint Committee on Government and Finance and the Public Employees Insurance Agency Finance Board.

(k) The Plan shall provide coverage for newly born children, up to the age of 19, for the medically necessary care and treatment to address congenital anomalies associated with cleft lip and cleft palate to include:

(1) Oral and facial surgery, including reconstructive services and procedures necessary to improve, restore, and maintain vital functions;

(2) Prosthetic treatment such as obdurators, speech appliances, and feeding appliances;

(3) Orthodontic treatment and management;

(4) Prosthodontic treatment and management;

(5) Otolaryngology treatment and management;

(6) The coverage requirements set forth in this subsection do not include cosmetic surgery performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve appearance; and

(7) The Public Employees Insurance Agency may impose the same deductible, coinsurance or other cost-sharing limitation that is imposed on other related surgical benefits under the Plan to the benefits for cleft lip and palate set forth in this article.

(l) This subdivision is effective for policy, contract, plans, or agreements beginning on or after July 1, 2025. This subdivision applies to all policies, contracts, plans, or agreements, subject to this subsection, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this subsection.

CHAPTER 9. HUMAN SERVICES.

ARTICLE 5. MISCELLANEOUS PROVISIONS.

§9-5-34. Required Coverage for Cleft Lip and Cleft Palate.

(a) Medicaid shall provide coverage for newly born children, up to the age of 19, for the medically necessary care and treatment to address congenital anomalies associated with cleft lip and cleft palate to include:

(1) Oral and facial surgery, including reconstructive services and procedures necessary to improve, restore, and maintain vital functions;

(2) Prosthetic treatment such as obdurators, speech appliances, and feeding appliances;

(3) Orthodontic treatment and management;

(4) Prosthodontic treatment and management;

(5) Otolaryngology treatment and management;

(6) The coverage requirements set forth in this subsection do not include cosmetic surgery

performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve appearance; and

(7) Medicaid may impose the same deductible, coinsurance or other cost-sharing limitation that is imposed on other related surgical benefits under the Plan to the benefits for cleft lip and palate set forth in this article.

(b) This subdivision is effective for policy, contract, plans, or agreements beginning on or after July 1, 2025. This subsection applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this subsection.

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4x. Required Coverage for Cleft Lip and Cleft Palate.

(a) The Insurer shall provide coverage for newly born children, up to the age of 19, for the medically necessary care and treatment to address congenital anomalies associated with cleft lip and cleft palate to include:

(1) Oral and facial surgery, including reconstructive services and procedures necessary to improve, restore, and maintain vital functions;

(2) Prosthetic treatment such as obdurators, speech appliances, and feeding appliances;

(3) Orthodontic treatment and management;

(4) Prosthodontic treatment and management;

(5) Otolaryngology treatment and management;

(6) The coverage requirements set forth in this subsection do not include cosmetic surgery performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve appearance; and

(7) The Insurer may impose the same deductible, coinsurance or other cost-sharing

limitation that is imposed on other related surgical benefits under the Plan to the benefits for cleft lip and palate set forth in this article.

(b) This subdivision is effective for policy, contract, plans, or agreements beginning on or after July 1, 2025. This subsection applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this subsection.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3rr. Required Coverage for Cleft Lip and Cleft Palate.

(a) The Insurer shall provide coverage for newly born children, up to the age of 19, for the medically necessary care and treatment to address congenital anomalies associated with cleft lip and cleft palate to include:

(1) Oral and facial surgery, including reconstructive services and procedures necessary to improve, restore, and maintain vital functions;

(2) Prosthetic treatment such as obdurators, speech appliances, and feeding appliances;

(3) Orthodontic treatment and management;

(4) Prosthodontic treatment and management;

(5) Otolaryngology treatment and management;

(6) The coverage requirements set forth in this subsection do not include cosmetic surgery performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve appearance; and

(7) The Insurer may impose the same deductible, coinsurance or other cost-sharing limitation that is imposed on other related surgical benefits under the plan to the benefits for cleft lip and palate set forth in this article.

(b) This subdivision is effective for policy, contract, plans, or agreements beginning on or after July 1, 2025. This subsection applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on

or after the effective date of this subsection.

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

§33-24-7y. Required Coverage for Cleft Lip and Cleft Palate.

(a) The Insurer shall provide coverage for newly born children, up to the age of 19, for the medically necessary care and treatment to address congenital anomalies associated with cleft lip and cleft palate to include:

(1) Oral and facial surgery, including reconstructive services and procedures necessary to improve, restore, and maintain vital functions;

(2) Prosthetic treatment such as obdurators, speech appliances, and feeding appliances;

(3) Orthodontic treatment and management;

(4) Prosthodontic treatment and management;

(5) Otolaryngology treatment and management;

(6) The coverage requirements set forth in this subsection do not include cosmetic surgery performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve appearance; and

(7) The Insurer may impose the same deductible, coinsurance or other cost-sharing limitation that is imposed on other related surgical benefits under the Plan to the benefits for cleft lip and palate set forth in this article.

(b) This subdivision is effective for policy, contract, plans, or agreements beginning on or after July 1, 2025. This subsection applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this subsection.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8v. Required Coverage for Cleft Lip and Cleft Palate.

(a) The Insurer shall provide coverage for newly born children, up to the age of 19, for the medically necessary care and treatment to address congenital anomalies associated with cleft lip and cleft palate to include:

(1) Oral and facial surgery, including reconstructive services and procedures necessary to improve, restore, and maintain vital functions;

(2) Prosthetic treatment such as obdurators, speech appliances, and feeding appliances;

(3) Orthodontic treatment and management;

(4) Prosthodontic treatment and management;

(5) Otolaryngology treatment and management;

(6) The coverage requirements set forth in this subsection do not include cosmetic surgery performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve appearance; and

(7) The Insurer may impose the same deductible, coinsurance or other cost-sharing limitation that is imposed on other related surgical benefits under the Plan to the benefits for cleft lip and palate set forth in this article.

(b) This subdivision is effective for policy, contract, plans, or agreements beginning on or after July 1, 2025. This subsection applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this subsection.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8y. Required Coverage for Cleft Lip and Cleft Palate.

(a) The Insurer shall provide coverage for newly born children, up to the age of 19, for the medically necessary care and treatment to address congenital anomalies associated with cleft lip and cleft palate to include:

(1) Oral and facial surgery, including reconstructive services and procedures necessary to

improve, restore, and maintain vital functions;

(2) Prosthetic treatment such as obdurators, speech appliances, and feeding appliances;

(3) Orthodontic treatment and management;

(4) Prosthodontic treatment and management;

(5) Otolaryngology treatment and management;

(6) The coverage requirements set forth in this subsection do not include cosmetic surgery performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve appearance; and

(7) The Insurer may impose the same deductible, coinsurance or other cost-sharing limitation that is imposed on other related surgical benefits under the Plan to the benefits for cleft lip and palate set forth in this article.

(b) This subdivision is effective for policy, contract, plans, or agreements beginning on or after July 1, 2025. This subsection applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this subsection.

NOTE: The purpose of this bill is to require coverage for newly born children up to the age of 19 for medically necessary congenital anomalies of cleft lip and palate.

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