

WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

Introduced

House Bill 4061

**FISCAL
NOTE**

By Delegate Crouse

[Introduced January 14, 2026; referred to the
Committee on Health and Human Resources then
Finance]

1 A BILL to amend and reenact §5-16-7, §33-15-4u, §33-16-3ff, §33-24-7u, §33-25-8r, and §33-
2 25A-8u of the Code of West Virginia, 1931, as amended, relating to requiring the Public
3 Employees Insurance Agency and other health insurance providers to provide payment
4 parity for the same services provided between behavioral health, mental health, and
5 medical and surgical health care providers; setting forth providers eligible for parity
6 payment; providing requirements for claim submission; prohibiting insurer from reducing
7 reimbursement paid to physician; and setting forth an 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.

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

4 (1) Coverages and benefits for x-ray and laboratory services in connection with
5 mammograms when medically appropriate and consistent with current guidelines from the United
6 States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology,
7 whichever is medically appropriate and consistent with the current guidelines from either the
8 United States Preventive Services Task Force or the American College of Obstetricians and
9 Gynecologists; and a test for the human papilloma virus when medically appropriate and

10 consistent with current guidelines from either the United States Preventive Services Task Force or
11 the American College of Obstetricians and Gynecologists, when performed for cancer screening
12 or diagnostic services on a woman age 18 or over;

13 (2) Annual checkups for prostate cancer in men age 50 and over;
14 (3) Annual screening for kidney disease as determined to be medically necessary by a
15 physician using any combination of blood pressure testing, urine albumin or urine protein testing,
16 and serum creatinine testing as recommended by the National Kidney Foundation;

17 (4) For plans that include maternity benefits, coverage for inpatient care in a duly licensed
18 health care facility for a mother and her newly born infant for the length of time which the attending
19 physician considers medically necessary for the mother or her newly born child. No plan may deny
20 payment for a mother or her newborn child prior to 48 hours following a vaginal delivery or prior to
21 96 hours following a caesarean section delivery if the attending physician considers discharge
22 medically inappropriate;

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

29 (6) Coverage for treatment of serious mental illness:

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

34 (i) Schizophrenia and other psychotic disorders;
35 (ii) Bipolar disorders;

36 (iii) Depressive disorders;

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

38 nicotine-related disorders;

39 (v) Anxiety disorders; and

40 (vi) Anorexia and bulimia.

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

44 (B) The agency shall not discriminate between medical-surgical benefits and mental health
45 benefits in the administration of its plan. With regard to both medical-surgical and mental health
46 benefits, it may make determinations of medical necessity and appropriateness and it may use
47 recognized health care quality and cost management tools including, but not limited to, limitations
48 on inpatient and outpatient benefits, utilization review, implementation of cost-containment
49 measures, preauthorization for certain treatments, setting coverage levels, setting maximum
50 number of visits within certain time periods, using capitated benefit arrangements, using fee-for-
51 service arrangements, using third-party administrators, using provider networks, and using patient
52 cost sharing in the form of copayments, deductibles, and coinsurance: Provided, That the
53 reimbursement for mental health care provided by a practitioner licensed pursuant to §30-7-7,
54 §30-21-8, §30-30-8, §30-30-10, §30-30-12, §30-31-8, and §30-31-9 of this code shall be in the
55 same amount as the reimbursement paid under the policy to a licensed physician performing such
56 care in the area served: Provided, however, That the claim is submitted using the diagnoses and
57 procedure codes applicable to the service, such licensed practitioner's name, the national provider
58 identifier for the licensed practitioner providing the service, and, if required by the insurer, the
59 facility in which the service is provided, and: Provided further, That no insurer shall reduce the
60 reimbursement paid to a licensed physician to comply with the provisions of this section.
61 Additionally, the agency shall comply with the financial requirements and quantitative treatment

62 limitations specified in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation. The agency
63 may not apply any nonquantitative treatment limitations to benefits for behavioral health, mental
64 health, and substance use disorders that are not applied to medical and surgical benefits within
65 the same classification of benefits: *Provided And provided further*, That any service, even if it is
66 related to the behavioral health, mental health, or substance use diagnosis if medical in nature,
67 shall be reviewed as a medical claim and undergo all utilization review as applicable;

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

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

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

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

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

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

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

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

99 (iii) There is an expectation that the anticipated improvement is attainable in a reasonable

100 and generally predictable period of time.

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

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

113 (10) (A) Coverage, through the age of 20, for amino acid-based formula for the treatment of

114 severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting
115 the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the
116 following conditions, if diagnosed as related to the disorder by a physician licensed to practice in
117 this state pursuant to either §30-3-1 *et seq.* or §30-14-1 *et seq.* of this code:

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

120 (ii) Severe food protein-induced enterocolitis syndrome;

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

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

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

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

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

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

140 provided at the time of immunization be exempt from any deductible or copayment provisions.

141 (12) The provision requiring coverage for 12-month refill for contraceptive drugs codified at
142 §33-58-1 of this code.

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

145 (b) The agency shall make available to each eligible employee, at full cost to the employee,
146 the opportunity to purchase optional group life and accidental death insurance as established
147 under the rules of the agency. In addition, each employee is entitled to have his or her spouse and
148 dependents, as defined by the rules of the agency, included in the optional coverage, at full cost to
149 the employee, for each eligible dependent.

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

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

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

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

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

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

163 (e) The agency shall establish procedures to authorize treatment with a nonparticipating
164 provider if a covered service is not available within established time and distance standards and
165 within a reasonable period after service is requested, and with the same coinsurance, deductible,

166 or copayment requirements as would apply if the service were provided at a participating provider,
167 and at no greater cost to the covered person than if the services were obtained at or from a
168 participating provider.

169 (f) If the Public Employees Insurance Agency offers a plan that does not cover services
170 provided by an out-of-network provider, it may provide the benefits required in paragraph (A),
171 subdivision (6), subsection (a) of this section if the services are rendered by a provider who is
172 designated by and affiliated with the Public Employees Insurance Agency, and only if the same
173 requirements apply for services for a physical illness.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

218 determine that the processes and strategies used to design each nonquantitative treatment
219 limitation, as written, and the written processes and strategies used to apply each nonquantitative
220 treatment limitation for benefits for behavioral health, mental health, and substance use disorders
221 are comparable to, and are applied no more stringently than, the processes and strategies used to
222 design and apply each nonquantitative treatment limitation, as written, and the written processes
223 and strategies used to apply each nonquantitative treatment limitation for medical and surgical
224 benefits;

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

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

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

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

242 (k) Changes made to this article in the 2026 Regular Session of the Legislature shall take
243 effect July 1, 2027.

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4u. **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 To the extent that coverage is provided "behavioral health, mental health, and substance
4 use disorder" means a condition or disorder, regardless of etiology, that may be the result of a
5 combination of genetic and environmental factors and that falls under any of the diagnostic
6 categories listed in the mental disorders section of the most recent version of:

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

11 Includes autism spectrum disorder: *Provided*, That any service, even if it is related to the
12 behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall be
13 reviewed as a medical claim and undergo all utilization review as applicable.

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

20 (c) The carrier shall:

21 (1) Include coverage and reimbursement for behavioral health screenings using a
22 validated screening tool for behavioral health, which coverage and reimbursement is no less

23 extensive than the coverage and reimbursement for the annual physical examination: Provided,
24 That the reimbursement for mental health care provided by a practitioner licensed pursuant to
25 §30-7-7, §30-21-8, §30-30-8, §30-30-10, §30-30-12, §30-31-8, and §30-31-9 of this code shall be
26 in the same amount as the reimbursement paid under the policy to a licensed physician performing
27 such care in the area served: Provided, however, That the claim is submitted using the diagnoses
28 and procedure codes applicable to the service, such licensed practitioner's name, the national
29 provider identifier for the licensed practitioner providing the service and, if required by the insurer,
30 the facility in which the service is provided, and: Provided further, That no insurer shall reduce the
31 reimbursement paid to a licensed physician to comply with the provisions of this section.

32 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR
33 §146.136(c)(4), or any successor regulation, regarding any limitations that are not expressed
34 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to
35 the limitations and examples listed in 45 CFR §146.136(c)(4)(ii) and (c)(4)(iii), or any successor
36 regulation and 78 FR 68246, include the methods by which the carrier establishes and maintains
37 its provider network and responds to deficiencies in the ability of its networks to provide timely
38 access to care;

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

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

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

49 participating provider; and

50 (6) If a covered person obtains a covered service from a nonparticipating provider because
51 the covered service is not available within the established time and distance standards, reimburse
52 treatment or services for behavioral health, mental health, or substance use disorders required to
53 be covered pursuant to this subsection that are provided by a nonparticipating provider using the
54 same methodology that the carrier uses to reimburse covered medical services provided by
55 nonparticipating providers and, upon request, provide evidence of the methodology to the person
56 or provider.

57 (d) If the carrier offers a plan that does not cover services provided by an out-of-network
58 provider, it may provide the benefits required in subsection (c) of this section if the services are
59 rendered by a provider who is designated by and affiliated with the carrier only if the same
60 requirements apply for services for a physical illness.

61 (e) In the event of a concurrent review for a claim for coverage of services for the
62 prevention of, screening for, and treatment of behavioral health, mental health, and substance use
63 disorders, the service continues to be a covered service until the carrier notifies the covered
64 person of the determination of the claim.

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

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

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

74 (3) A statement specifying that covered persons are entitled, upon request to the carrier, to

75 a copy of the medical necessity criteria for any behavioral health, mental health, and substance
76 use disorder benefit.

77 (g) On or after June 1, 2021, and annually thereafter, the Insurance Commissioner shall
78 submit a written report to the Joint Committee on Government and Finance that contains the
79 following information on plans which fall under this section regarding plans offered pursuant to this
80 section:

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

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

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

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

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

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

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

101 treatment limitations shall include at a minimum:

102 (A) Identifying factors used to determine whether a nonquantitative treatment limitation

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

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

105 other evidence relied on in designing each nonquantitative treatment limitation;

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

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

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

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

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

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

112 and strategies used to apply each nonquantitative treatment limitation for medical and surgical

113 benefits;

114 (D) Provide the comparative analyses, including the results of the analyses, performed to

115 determine that the processes and strategies used to apply each nonquantitative treatment

116 limitation, in operation, for benefits for behavioral health, mental health, and substance use

117 disorders are comparable to, and are applied no more stringently than, the processes and

118 strategies used to apply each nonquantitative treatment limitation, in operation, for medical and

119 surgical benefits; and

120 (E) Disclose the specific findings and conclusions reached by the Insurance Commissioner

121 that the results of the analyses indicate that each health benefit plan offered under the provisions

122 of this section complies with subsection (c) of this section.

123 (h) The Insurance Commissioner shall adopt legislative rules to comply with the provisions

124 of this section. These rules shall specify the information and analyses that carriers shall provide to

125 the Insurance Commissioner necessary for the Insurance Commissioner to complete the report

126 described in subsection (g) of this section and shall delineate the format in which the carriers shall

127 submit such information and analyses. These rules or amendments to rules shall be proposed
128 pursuant to the provisions of §29A-3-1 *et seq.* of this code within the applicable time limit to be
129 considered by the Legislature during its regular session in the year 2021. The rules shall require
130 that each carrier first submit the report to the Insurance Commissioner no earlier than one year
131 after the rules are promulgated, and any year thereafter during which the carrier makes significant
132 changes to how it designs and applies medical management protocols.

133 (i) This section is effective for policies, contracts, plans, or agreements, beginning on or
134 after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject
135 to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on
136 or after the effective date of this section.

137 (j) The Insurance Commissioner shall enforce this section and may conduct a financial
138 examination of the carrier to determine if it is in compliance with this section, including, but not
139 limited to, a review of policies and procedures and a sample of mental health claims to determine
140 these claims are treated in parity with medical and surgical benefits. The results of this
141 examination shall be reported to the Legislature. If the Insurance Commissioner determines that
142 the carrier is not in compliance with this section, the Insurance Commissioner may fine the carrier
143 in conformity with the fines established in the legislative rule.

144 (k) Changes made to this article in the 2026 Regular Session of the Legislature shall take
145 effect July 1, 2027.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3ff. 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 To the extent that coverage is provided "behavioral, mental health, and substance use
4 disorder" means a condition or disorder, regardless of etiology, that may be the result of a
5 combination of genetic and environmental factors and that falls under any of the diagnostic

6 categories listed in the mental disorders section 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: *Provided*, That any service, even if it is related to the
12 behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall be
13 reviewed as a medical claim and undergo all utilization review as applicable.

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

20 (c) The carrier shall:

21 (1) Include coverage and reimbursement for behavioral health screenings using a
22 validated screening tool for behavioral health, which coverage and reimbursement is no less
23 extensive than the coverage and reimbursement for the annual physical examination: *Provided*,
24 That the reimbursement for mental health care provided by a practitioner licensed pursuant to §30-
25 7-7, §30-21-8, §30-30-8, §30-30-10, §30-30-12, §30-31-8, and §30-31-9 of this code shall be in
26 the same amount as the reimbursement paid under the policy to a licensed physician performing
27 such care in the area served: Provided, however, That the claim is submitted using the diagnoses
28 and procedure codes applicable to the service, such licensed practitioner's name, the national
29 provider identifier for the licensed practitioner providing the service and, if required by the insurer,
30 the facility in which the service is provided: Provided further, That no insurer shall reduce the
31 reimbursement paid to a licensed physician to comply with the provisions of this section.

32 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR
33 §146.136(c)(4), or any successor regulation, regarding any limitations that are not expressed
34 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to
35 the limitations and examples listed in 45 CFR §146.136(c)(4)(ii) and (c)(4)(iii), or any successor
36 regulation and 78 FR 68246, include the methods by which the carrier establishes and maintains
37 its provider network and responds to deficiencies in the ability of its networks to provide timely
38 access to care;

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

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

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

50 (6) If a covered person obtains a covered service from a nonparticipating provider because
51 the covered service is not available within the established time and distance standards, reimburse
52 treatment or services for behavioral health, mental health, or substance use disorders required to
53 be covered pursuant to this subsection that are provided by a nonparticipating provider using the
54 same methodology that the carrier uses to reimburse covered medical services provided by
55 nonparticipating providers and, upon request, provide evidence of the methodology to the person
56 or provider.

57 (d) If the carrier offers a plan that does not cover services provided by an out-of-network

58 provider, it may provide the benefits required in subsection (c) of this section if the services are
59 rendered by a provider who is designated by and affiliated with the carrier only if the same
60 requirements apply for services for a physical illness.

61 (e) In the event of a concurrent review for a claim for coverage of services for the
62 prevention of, screening for, and treatment of behavioral health, mental health, and substance use
63 disorders, the service continues to be a covered service until the carrier notifies the covered
64 person of the determination of the claim.

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

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

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

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

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

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

83 (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; and

(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.

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

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

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

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

110 design and apply each nonquantitative treatment limitation, as written, and the written processes
111 and strategies used to apply each nonquantitative treatment limitation for medical and surgical
112 benefits;

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

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

122 (h) The Insurance Commissioner shall adopt legislative rules to comply with the provisions
123 of this section. These rules shall specify the information and analyses that carriers shall provide to
124 the Insurance Commissioner necessary for the commissioner to complete the report described in
125 subsection (g) of this section and shall delineate the format in which carriers shall submit such
126 information and analyses. These rules or amendments to rules shall be proposed pursuant to the
127 provisions of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the
128 Legislature during its regular session in the year 2021. The rules shall require that each carrier first
129 submit the report to the Insurance Commissioner no earlier than one year after the rules are
130 promulgated, and any year thereafter during which the carrier makes significant changes to how it
131 designs and applies medical management protocols.

132 (i) This section is effective for policies, contracts, plans or agreements, beginning on or
133 after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject
134 to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on
135 or after the effective date of this section.

136 (j) The Insurance Commissioner shall enforce this section and may conduct a financial
137 examination of the carrier to determine if it is in compliance with this section, including, but not
138 limited to, a review of policies and procedures and a sample of mental health claims to determine
139 these claims are treated in parity with medical and surgical benefits. The results of this
140 examination shall be reported to the Legislature. If the Insurance Commissioner determines that
141 the carrier is not in compliance with this section, the Insurance Commissioner may fine the carrier
142 in conformity with the fines established in the legislative rule.

143 (k) Changes made to this article in the 2026 Regular Session of the Legislature shall take
144 effect July 1, 2027.

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

§33-24-7u. 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 To the extent that coverage is provided "behavioral health, mental health, and substance
4 use disorder" means a condition or disorder, regardless of etiology, that may be the result of a
5 combination of genetic and environmental factors and that falls under any of the diagnostic
6 categories listed in the mental disorders section 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: *Provided*, That any service, even if it is related to the
12 behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall be

13 reviewed as a medical claim and undergo all utilization review as applicable.

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

20 (c) The carrier shall:

21 (1) Include coverage and reimbursement for behavioral health screenings using a
22 validated screening tool for behavioral health, which coverage and reimbursement is no less
23 extensive than the coverage and reimbursement for the annual physical examination: *Provided,*
24 That the reimbursement for mental health care provided by a practitioner licensed pursuant to §30-
25 7-7, §30-21-8, §30-30-8, §30-30-10, §30-30-12, §30-31-8, and §30-31-9 of this code shall be in
26 the same amount as the reimbursement paid under the policy to a licensed physician performing
27 such care in the area served: *Provided, however* That the claim is submitted using the diagnoses
28 and procedure codes applicable to the service, such licensed practitioner's name, the national
29 provider identifier for the licensed practitioner providing the service and, if required by the insurer,
30 the facility in which the service is provided: *Provided further,* That no insurer shall reduce the
31 reimbursement paid to a licensed physician to comply with the provisions of this section.

32 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR
33 §146.136(c)(4), or any successor regulation, regarding any limitations that are not expressed
34 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to
35 the limitations and examples listed in 45 CFR §146.136(c)(4)(ii) and (c)(4)(iii), or any successor
36 regulation and 78 FR 68246, include the methods by which the carrier establishes and maintains
37 its provider network and responds to deficiencies in the ability of its networks to provide timely
38 access to care;

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

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

44 (5) Establish procedures to authorize treatment with a nonparticipating provider if a
45 covered service is not available within established time and distance standards and within a
46 reasonable period after service is requested, and with the same coinsurance, deductible, or
47 copayment requirements as would apply if the service were provided at, a participating provider;

48 (6) If a covered person obtains a covered service from a nonparticipating provider because
49 the covered service is not available within the established time and distance standards, reimburse
50 treatment or services for behavioral health, mental health, or substance use disorders required to
51 be covered pursuant to this subsection that are provided by a nonparticipating provider using the
52 same methodology that the carrier uses to reimburse covered medical services provided by
53 nonparticipating providers and, upon request, provide evidence of the methodology to the person
54 or provider.

55 (d) If the carrier offers a plan that does not cover services provided by an out-of-network
56 provider, it may provide the benefits required in subsection (c) of this section if the services are
57 rendered by a provider who is designated by and affiliated with the carrier only if the same
58 requirements apply for services for a physical illness.

59 (e) In the event of a concurrent review for a claim for coverage of services for the
60 prevention of, screening for, and treatment of behavioral health, mental health, and substance use
61 disorders, the service continues to be a covered service until the carrier notifies the covered
62 person of the determination of the claim.

63 (f) Unless denied for nonpayment of premium, a denial of reimbursement for services for
64 the prevention of, screening for, or treatment of behavioral health, mental health, and substance

65 use disorders by the carrier must include the following language:

66 (1) A statement explaining that covered persons are protected under this section, which

67 provides that limitations placed on the access to mental health and substance use disorder

68 benefits may be no greater than any limitations placed on access to medical and surgical benefits;

69 (2) A statement providing information about the Consumer Services Division of the Office

70 of the West Virginia Insurance Commissioner if the covered person believes his or her rights under

71 this section have been violated; and

72 (3) A statement specifying that covered persons are entitled, upon request to the carrier, to

73 a copy of the medical necessity criteria for any behavioral health, mental health, and substance

74 use disorder benefit.

75 (g) On or after June 1, 2021, and annually thereafter, the Insurance Commissioner shall

76 submit a written report to the Joint Committee on Government and Finance that contains the

77 following information regarding plans offered pursuant to this section:

78 (1) Data that demonstrates parity compliance for adverse determination regarding claims

79 for behavioral health, mental health, or substance use disorder services and includes the total

80 number of adverse determinations for such claims;

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

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

83 mental health, and substance use disorders; and

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

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

86 behavioral health, mental health, and substance use disorders and to medical and surgical

87 benefits within each classification of benefits; and

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

89 subdivision (2) of this subsection and for each nonquantitative treatment limitation identified in

90 subdivision (3) of this subsection, as written and in operation, the processes, strategies,

91 evidentiary standards, or other factors used in applying the medical necessity criteria and each
92 nonquantitative treatment limitation to benefits for behavioral health, mental health, and substance
93 use disorders within each classification of benefits are comparable to, and are applied no more
94 stringently than, the processes, strategies, evidentiary standards, or other factors used in applying
95 the medical necessity criteria and each nonquantitative treatment limitation to medical and
96 surgical benefits within the corresponding classification of benefits.

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

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

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

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

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

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

120 (h) The Insurance Commissioner shall adopt legislative rules to comply with the provisions
121 of this section. These rules shall specify the information and analyses that carriers shall provide to
122 the Insurance Commissioner necessary for the commissioner to complete the report described in
123 subsection (g) of this section and shall delineate the format in which carriers shall submit such
124 information and analyses. These rules or amendments to rules shall be proposed pursuant to the
125 provisions of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the
126 Legislature during its regular session in the year 2021. The rules shall require that each carrier first
127 submit the report to the Insurance Commissioner no earlier than one year after the rules are
128 promulgated, and any year thereafter during which the carrier makes significant changes to how it
129 designs and applies medical management protocols.

130 (i) This section is effective for policies, contracts, plans or agreements, beginning on or
131 after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject
132 to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on
133 or after the effective date of this section.

134 (j) The Insurance Commissioner shall enforce this section and may conduct a financial
135 examination of the carrier to determine if it is in compliance with this section, including, but not
136 limited to, a review of policies and procedures and a sample of mental health claims to determine
137 these claims are treated in parity with medical and surgical benefits. The results of this
138 examination shall be reported to the Legislature. If the Insurance Commissioner determines that
139 the carrier is not in compliance with this section, the Insurance Commissioner may fine the carrier
140 in conformity with the fines established in the legislative rule.

141 (k) Changes made to this article in the 2026 Regular Session of the Legislature shall take
142 effect July 1, 2027.

ARTICLE 25. HEALTH CARE CORPORATIONS.**§33-25-8r. 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 To the extent that coverage is provided "behavioral health, mental health, and substance
4 use disorder" means a condition or disorder, regardless of etiology, that may be the result of a
5 combination of genetic and environmental factors and that falls under any of the diagnostic
6 categories listed in the mental disorders section 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: *Provided*, That any service, even if it is related to the
12 behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall be
13 reviewed as a medical claim and undergo all utilization review as applicable.

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

20 (c) The carrier shall:

21 (1) Include coverage and reimbursement for behavioral health screenings using a
22 validated screening tool for behavioral health, which coverage and reimbursement is no less
23 extensive than the coverage and reimbursement for the annual physical examination: *Provided*,
24 That the reimbursement for mental health care provided by a practitioner licensed pursuant to §30-

25 7-7, §30-21-8, §30-30-8, §30-30-10, §30-30-12, §30-31-8, and §30-31-9 of this code shall be in
26 the same amount as the reimbursement paid under the policy to a licensed physician performing
27 such care in the area served: *Provided, however, That the claim is submitted using the diagnoses*
28 and procedure codes applicable to the service, such licensed practitioner's name, the national
29 provider identifier for the licensed practitioner providing the service and, if required by the insurer,
30 the facility in which the service is provided: and: *Provided further, That no insurer shall reduce the*
31 reimbursement paid to a licensed physician to comply with the provisions of this section.

32 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR
33 §146.136(c)(4), or any successor regulation, regarding any limitations that are not expressed
34 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to
35 the limitations and examples listed in 45 CFR §146.136(c)(4)(ii) and (c)(4)(iii), or any successor
36 regulation and 78 FR 68246, include the methods by which the carrier establishes and maintains
37 its provider network and responds to deficiencies in the ability of its networks to provide timely
38 access to care;

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

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

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

50 (6) If a covered person obtains a covered service from a nonparticipating provider because

51 the covered service is not available within the established time and distance standards, reimburse
52 treatment or services for behavioral health, mental health, or substance use disorders required to
53 be covered pursuant to this subsection that are provided by a nonparticipating provider using the
54 same methodology that the carrier uses to reimburse covered medical services provided by
55 nonparticipating providers and, upon request, provide evidence of the methodology to the person
56 or provider.

57 (d) If the carrier offers a plan that does not cover services provided by an out-of-network
58 provider, it may provide the benefits required in subsection (c) of this section if the services are
59 rendered by a provider who is designated by and affiliated with the carrier only if the same
60 requirements apply for services for a physical illness.

61 (e) In the event of a concurrent review for a claim for coverage of services for the
62 prevention of, screening for, and treatment of behavioral health, mental health, and substance use
63 disorders, the service continues to be a covered service until the carrier notifies the covered
64 person of the determination of the claim.

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

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

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

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

(g) On or after June 1, 2021, and annually thereafter, the Insurance Commissioner shall a written report to the Joint Committee on Government and Finance that contains the 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, health, 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 oral health, mental health, and substance use disorders and to medical and surgical services within each classification of benefits; and

(4) The results of analyses demonstrating that, for medical necessity criteria described in section (2) of this subsection and for each nonquantitative treatment limitation identified in section (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 quantitative treatment limitation to benefits for behavioral health, mental health, and substance 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 medical necessity criteria and each nonquantitative treatment limitation to medical and dental benefits within the corresponding classification of benefits.

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

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

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

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

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

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

122 (h) The Insurance Commissioner shall adopt legislative rules to comply with the provisions
123 of this section. These rules shall specify the information and analyses that carriers shall provide to
124 the Insurance Commissioner necessary for the commissioner to complete the report described in
125 subsection (g) of this section and shall delineate the format in which carriers shall submit such
126 information and analyses. These rules or amendments to rules shall be proposed pursuant to the
127 provisions of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the
128 Legislature during its regular session in the year 2021. The rules shall require that each carrier first

129 submit the report to the Insurance Commissioner no earlier than one year after the rules are
130 promulgated, and any year thereafter during which the carrier makes significant changes to how it
131 designs and applies medical management protocols.

132 (i) This section is effective for policies, contracts, plans or agreements, beginning on or
133 after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject
134 to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on
135 or after the effective date of this section.

136 (j) The Insurance Commissioner shall enforce this section and may conduct a financial
137 examination of the carrier to determine if it is in compliance with this section, including, but not
138 limited to, a review of policies and procedures and a sample of mental health claims to determine
139 these claims are treated in parity with medical and surgical benefits. The results of this
140 examination shall be reported to the Legislature. If the Insurance Commissioner determines that
141 the carrier is not in compliance with this section, the Insurance Commissioner may fine the carrier
142 in conformity with the fines established in the legislative rule.

143 (k) Changes made to this article in the 2026 Regular Session of the Legislature shall take
144 effect July 1, 2027.

ARTICLE	25A.	HEALTH	MAINTENANCE	ORGANIZATION	ACT.
		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 To the extent that coverage is provided "behavioral health, mental health, and substance
4 use disorder" means a condition or disorder, regardless of etiology, that may be the result of a
5 combination of genetic and environmental factors and that falls under any of the diagnostic
6 categories listed in the mental disorders section 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: *Provided*, That any service, even if it is related to the
12 behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall be
13 reviewed as a medical claim and undergo all utilization review as applicable.

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

20 (c) The carrier shall:

21 (1) Include coverage and reimbursement for behavioral health screenings using a
22 validated screening tool for behavioral health, which coverage and reimbursement is no less
23 extensive than the coverage and reimbursement for the annual physical examination: Provided,
24 That the reimbursement for mental health care provided by a practitioner licensed pursuant to §30-
25 7-7, §30-21-8, §30-30-8, §30-30-10, §30-30-12, §30-31-8, and §30-31-9 of this code shall be in
26 the same amount as the reimbursement paid under the policy to a licensed physician performing
27 such care in the area served: *Provided, however* That the claim is submitted using the diagnoses
28 and procedure codes applicable to the service, such licensed practitioner's name, the national
29 provider identifier for the licensed practitioner providing the service and, if required by the insurer,
30 the facility in which the service is provided: *Provided further*, That no insurer shall reduce the
31 reimbursement paid to a licensed physician to comply with the provisions of this section.

32 (2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR
33 §146.136(c)(4), or any successor regulation, regarding any limitations that are not expressed
34 numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to

35 the limitations and examples listed in 45 CFR §146.136(c)(4)(ii) and (c)(4)(iii), or any successor
36 regulation and 78 FR 68246, include the methods by which the carrier establishes and maintains
37 its provider network and responds to deficiencies in the ability of its networks to provide timely
38 access to care;

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

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

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

50 (6) If a covered person obtains a covered service from a nonparticipating provider because
51 the covered service is not available within the established time and distance standards, reimburse
52 treatment or services for behavioral health, mental health, or substance use disorders required to
53 be covered pursuant to this subsection that are provided by a nonparticipating provider using the
54 same methodology that the carrier uses to reimburse covered medical services provided by
55 nonparticipating providers and, upon request, provide evidence of the methodology to the person
56 or provider.

57 (d) If the carrier offers a plan that does not cover services provided by an out-of-network
58 provider, it may provide the benefits required in subsection (c) of this section if the services are
59 rendered by a provider who is designated by and affiliated with the carrier only if the same
60 requirements apply for services for a physical illness.

61 (e) In the event of a concurrent review for a claim for coverage of services for the
62 prevention of, screening for, and treatment of behavioral health, mental health, and substance use
63 disorders, the service continues to be a covered service until the carrier notifies the covered
64 person of the determination of the claim.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

122 (h) The Insurance Commissioner shall adopt legislative rules to comply with the provisions
123 of this section. These rules shall specify the information and analyses that carriers shall provide to
124 the Insurance Commissioner necessary for the commissioner to complete the report described in
125 subsection (g) of this section and shall delineate the format in which carriers shall submit such
126 information and analyses. These rules or amendments to rules shall be proposed pursuant to the
127 provisions of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the
128 Legislature during its regular session in the year 2021. The rules shall require that each carrier first
129 submit the report to the Insurance Commissioner no earlier than one year after the rules are
130 promulgated, and any year thereafter during which the carrier makes significant changes to how it
131 designs and applies medical management protocols.

132 (i) This section is effective for policies, contracts, plans or agreements, beginning on or
133 after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject
134 to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on
135 or after the effective date of this section.

136 (j) The Insurance Commissioner shall enforce this section and may conduct a financial
137 examination of the carrier to determine if it is in compliance with this section, including, but not
138 limited to, a review of policies and procedures and a sample of mental health claims to determine

139 these claims are treated in parity with medical and surgical benefits. The results of this
140 examination shall be reported to the Legislature. If the Insurance Commissioner determines that
141 the carrier is not in compliance with this section, the Insurance Commissioner may fine the carrier
142 in conformity with the fines established in the legislative rule.

143 (k) Changes made to this article in the 2026 Regular Session of the Legislature shall take
144 effect July 1, 2027.

NOTE: The purpose of this bill is to provide payment parity for mental health care delivered by non-physicians for identical services provided by physicians.

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