WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

Introduced

Senate Bill 518

FISCAL NOTE

By Senator Chapman

[Introduced January 20, 2026; referred

to the Committee on Health and Human Resources;

and then to the Committee on Finance]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding six new sections, designated §5-16-7h, §33-15-4y, §33-16-3ii, §33-24-7z, §33-25-8w, and §33-25A-8z, relating to cost-sharing requirements for breast examinations; defining terms; prohibiting cost-sharing requirements; permitting existing utilization review; addressing health savings account ineligibility; permitting rulemaking; and providing 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.

§5-16-7h. Cost-sharing requirements for diagnostic and supplemental breast examinations.

(a) As used in this section:

(1) "Cost-sharing requirement" means a deductible, coinsurance, copayment, or similar out-of-pocket expense;

(2) "Diagnostic breast examinations" mean a medically necessary and clinically appropriate breast examination utilizing guidelines established by a professional medical organization, including such examinations using breast MRI, breast ultrasound, or diagnostic mammogram, that is:

(A) Used to evaluate an abnormality seen or suspected from a screening examination for breast cancer; or

(B) Used to evaluate an abnormality detected by another means of examination.

(3) "Health benefit policy" means any individual or group plan, policy, or contract for health

care services issued, delivered, issued for delivery, executed, or renewed by an insurer in this state;

(4) "Insurer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Insurance Commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including government agencies and any insurer subject to §5-16-1 *et seq.*, of this code;

(5) "Supplemental breast examinations" mean a medically necessary and clinically appropriate, examination of the breast, utilizing current guidelines established by a professional medical organization, including such examinations using breast MRI and breast ultrasound, that is:

(A) Used to screen for breast cancer when there is no abnormality seen or suspected in the breast; and

(B) Based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

(b) In the case that a health benefit policy provides coverage with respect to screening, diagnostic breast examinations, and supplemental breast examinations, such policy shall not impose any cost sharing requirements.

(c) Nothing in this section shall be construed to preclude existing utilization review.

(d) If under federal law application of subsection (b) would result in Health Savings Account ineligibility under Section 223 of the Internal Revenue Code, such cost-sharing requirement shall apply only for Health Savings Account qualified High Deductible Health Plans with respect to the deductible of such plan after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code, except with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirements of subsection (b) of this section shall apply regardless of whether the minimum deductible under

Section 223 of the Internal Revenue Code has been satisfied.

(e) The Insurance Commissioner may propose rules for legislative approval in accordance with the provisions of §29A-3-1 *et seq*. of this code necessary to implement the provisions of this section in accordance with current guidelines established by professional medical organizations such as the National Comprehensive Cancer Network.

(f) This section applies to all coverage issued by this agency delivered, issued for delivery, reissued, or extended in the state on and after July 1, 2027, or at any time thereafter when any term of the policy, contract, or plan is changed, or any premium adjustment is made.

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4y. Cost-sharing requirements for diagnostic and supplemental breast examinations.

(a) As used in this section:

(1) "Cost-sharing requirement" means a deductible, coinsurance, copayment, or similar out-of-pocket expense;

(2) "Diagnostic breast examinations" mean a medically necessary and clinically appropriate breast examination utilizing guidelines established by a professional medical organization, including such examinations using breast MRI, breast ultrasound, or diagnostic mammogram, that is:

(A) Used to evaluate an abnormality seen or suspected from a screening examination for breast cancer; or

(B) Used to evaluate an abnormality detected by another means of examination.

(3) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed by an insurer in this state;

(4) "Insurer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Insurance Commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including government agencies and any insurer subject to §33-15-1 *et seq.*, of this code;

(5) "Supplemental breast examinations" mean a medically necessary and clinically appropriate, examination of the breast, utilizing current guidelines established by a professional medical organization, including such examinations using breast MRI and breast ultrasound, that is:

(A) Used to screen for breast cancer when there is no abnormality seen or suspected in the breast; and

(B) Based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

(b) In the case that a health benefit policy provides coverage with respect to screening, diagnostic breast examinations, and supplemental breast examinations, such policy shall not impose any cost sharing requirements.

(c) Nothing in this section shall be construed to preclude existing utilization review.

(d) If under federal law application of subsection (b) would result in Health Savings Account ineligibility under Section 223 of the Internal Revenue Code, such cost-sharing requirement shall apply only for Health Savings Account qualified High Deductible Health Plans with respect to the deductible of such plan after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code, except with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirements of subsection (b) of this section shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

(e) The Insurance Commissioner may propose rules for legislative approval in accordance

with the provisions of §29A-3-1 *et seq*. of this code necessary to implement the provisions of this section in accordance with current guidelines established by professional medical organizations such as the National Comprehensive Cancer Network.

(f) This section applies to all coverage issued by this insurer subject to this article delivered, issued for delivery, reissued, or extended in the state on and after January 1, 2027, or at any time thereafter when any term of the policy, contract, or plan is changed, or any premium adjustment is made.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3ii. Cost-sharing requirements for diagnostic and supplemental breast examinations.

(a) As used in this section:

(1) "Cost-sharing requirement" means a deductible, coinsurance, copayment, or similar out-of-pocket expense;

(2) "Diagnostic breast examinations" mean a medically necessary and clinically appropriate breast examination utilizing guidelines established by a professional medical organization, including such examinations using breast MRI, breast ultrasound, or diagnostic mammogram, that is:

(A) Used to evaluate an abnormality seen or suspected from a screening examination for breast cancer; or

(B) Used to evaluate an abnormality detected by another means of examination.

(3) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed by an insurer in this state;

(4) "Insurer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Insurance Commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of

health care services, including government agencies and any insurer subject to §33-16-1 *et seq.* of this code;

(5) "Supplemental breast examinations" mean a medically necessary and clinically appropriate, examination of the breast, utilizing current guidelines established by a professional medical organization, including such examinations using breast MRI and breast ultrasound, that is:

(A) Used to screen for breast cancer when there is no abnormality seen or suspected in the breast; and

(B) Based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

(b) In the case that a health benefit policy provides coverage with respect to screening, diagnostic breast examinations, and supplemental breast examinations, such policy shall not impose any cost sharing requirements.

(c) Nothing in this section shall be construed to preclude existing utilization review.

(d) If under federal law application of subsection (b) would result in Health Savings Account ineligibility under Section 223 of the Internal Revenue Code, such cost-sharing requirement shall apply only for Health Savings Account qualified High Deductible Health Plans with respect to the deductible of such plan after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code, except with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirements of subsection (b) of this section shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

(e) The Insurance Commissioner may propose rules for legislative approval in accordance with the provisions of §29A-3-1 *et seq.* of this code necessary to implement the provisions of this section in accordance with current guidelines established by professional medical organizations such as the National Comprehensive Cancer Network.

(f) This section applies to all coverage issued by this insurer delivered, issued for delivery, reissued, or extended in the state on and after January 1, 2027, or at any time thereafter when any term of the policy, contract, or plan is changed, or any premium adjustment is made.

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

§33-24-7z. Cost-sharing requirements for diagnostic and supplemental breast examinations.

(a) As used in this section:

(1) "Cost-sharing requirement" means a deductible, coinsurance, copayment, or similar out-of-pocket expense;

(2) "Diagnostic breast examinations" mean a medically necessary and clinically appropriate breast examination utilizing guidelines established by a professional medical organization, including such examinations using breast MRI, breast ultrasound, or diagnostic mammogram, that is:

(A) Used to evaluate an abnormality seen or suspected from a screening examination for breast cancer; or

(B) Used to evaluate an abnormality detected by another means of examination.

(3) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed by an insurer in this state;

(4) "Insurer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Insurance Commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including government agencies and any insurer subject to §33-24-1 *et seq.*

of this code;

(5) "Supplemental breast examinations" mean a medically necessary and clinically appropriate, examination of the breast, utilizing current guidelines established by a professional medical organization, including such examinations using breast MRI and breast ultrasound, that is:

(A) Used to screen for breast cancer when there is no abnormality seen or suspected in the breast; and

(B) Based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

(b) In the case that a health benefit policy provides coverage with respect to screening, diagnostic breast examinations, and supplemental breast examinations, such policy shall not impose any cost sharing requirements.

(c) Nothing in this section shall be construed to preclude existing utilization review.

(d) If under federal law application of subsection (b) would result in Health Savings Account ineligibility under Section 223 of the Internal Revenue Code, such cost-sharing requirement shall apply only for Health Savings Account qualified High Deductible Health Plans with respect to the deductible of such plan after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code, except with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirements of subsection (b) of this section shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

(e) The Insurance Commissioner may propose rules for legislative approval in accordance with the provisions of §29A-3-1 *et seq.* of this code necessary to implement the provisions of this section in accordance with current guidelines established by professional medical organizations such as the National Comprehensive Cancer Network.

(f) This section applies to all coverage issued by this insurer delivered, issued for delivery,

reissued, or extended in the state on and after January 1, 2027, or at any time thereafter when any term of the policy, contract, or plan is changed, or any premium adjustment is made.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8w. Cost-sharing requirements for diagnostic and supplemental breast examinations.

(a) As used in this section:

(1) "Cost-sharing requirement" means a deductible, coinsurance, copayment, or similar out-of-pocket expense;

(2) "Diagnostic breast examinations" mean a medically necessary and clinically appropriate breast examination utilizing guidelines established by a professional medical organization, including such examinations using breast MRI, breast ultrasound, or diagnostic mammogram, that is:

(A) Used to evaluate an abnormality seen or suspected from a screening examination for breast cancer; or

(B) Used to evaluate an abnormality detected by another means of examination.

(3) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed by an insurer in this state;

(4) "Insurer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Insurance Commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including government agencies and any insurer subject to §33-25-1 *et seq.* of this code;

(5) "Supplemental breast examinations" mean a medically necessary and clinically appropriate, examination of the breast, utilizing current guidelines established by a professional medical organization, including such examinations using breast MRI and breast ultrasound, that

is:

(A) Used to screen for breast cancer when there is no abnormality seen or suspected in the breast; and

(B) Based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

(b) In the case that a health benefit policy provides coverage with respect to screening, diagnostic breast examinations, and supplemental breast examinations, such policy shall not impose any cost sharing requirements.

(c) Nothing in this section shall be construed to preclude existing utilization review.

(d) If under federal law application of subsection (b) would result in Health Savings Account ineligibility under Section 223 of the Internal Revenue Code, such cost-sharing requirement shall apply only for Health Savings Account qualified High Deductible Health Plans with respect to the deductible of such plan after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code, except with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirements of subsection (b) of this section shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

(e) The Insurance Commissioner may propose rules for legislative approval in accordance with the provisions of §29A-3-1 *et seq.* of this code necessary to implement the provisions of this section in accordance with current guidelines established by professional medical organizations such as the National Comprehensive Cancer Network.

(f) This section applies to all coverage issued by this insurer delivered, issued for delivery, reissued, or extended in the state on and after January 1, 2027, or at any time thereafter when any term of the policy, contract, or plan is changed, or any premium adjustment is made.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8z. Cost-sharing requirements for diagnostic and supplemental breast

examinations.

(a) As used in this section:

(1) "Cost-sharing requirement" means a deductible, coinsurance, copayment, or similar out-of-pocket expense;

(2) "Diagnostic breast examinations" mean a medically necessary and clinically appropriate breast examination utilizing guidelines established by a professional medical organization, including such examinations using breast MRI, breast ultrasound, or diagnostic mammogram, that is:

(A) Used to evaluate an abnormality seen or suspected from a screening examination for breast cancer; or

(B) Used to evaluate an abnormality detected by another means of examination.

(3) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed by an insurer in this state;

(4) "Insurer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Insurance Commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including government agencies and any insurer subject to §33-25A-1 *et seq.* of this code;

(5) "Supplemental breast examinations" mean a medically necessary and clinically appropriate, examination of the breast, utilizing current guidelines established by a professional medical organization, including such examinations using breast MRI and breast ultrasound, that is:

(A) Used to screen for breast cancer when there is no abnormality seen or suspected in the breast; and

(B) Based on personal or family medical history or additional factors that may increase the

individual's risk of breast cancer.

(b) In the case that a health benefit policy provides coverage with respect to screening, diagnostic breast examinations, and supplemental breast examinations, such policy shall not impose any cost sharing requirements.

(c) Nothing in this section shall be construed to preclude existing utilization review.

(d) If under federal law application of subsection (b) would result in Health Savings Account ineligibility under Section 223 of the Internal Revenue Code, such cost-sharing requirement shall apply only for Health Savings Account qualified High Deductible Health Plans with respect to the deductible of such plan after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code, except with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirements of subsection (b) of this section shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

(e) The Insurance Commissioner may propose rules for legislative approval in accordance with the provisions of §29A-3-1 *et seq.* of this code necessary to implement the provisions of this section in accordance with current guidelines established by professional medical organizations such as the National Comprehensive Cancer Network.

(f) This section applies to all coverage issued by this insurer delivered, issued for delivery, reissued, or extended in the state on and after January 1, 2027, or at any time thereafter when any term of the policy, contract, or plan is changed, or any premium adjustment is made.

NOTE: The purpose of this bill is to require insurance providers to provide diagnostic and supplemental breast examinations without cost sharing.

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