

# **WEST VIRGINIA LEGISLATURE**

## **2026 REGULAR SESSION**

**Introduced**

### **Senate Bill 565**

By Senator Chapman

[Introduced January 21, 2026; referred  
to the Committee on Health and Human Resources;  
and then to the Committee on 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;

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 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.

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

To the extent that coverage is provided "behavioral health, mental health, and substance disorder" means a condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of:

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

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

### (3) The Diagnostic Classification of Mental Health and Developmental Disorders of 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 §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.

<b>ARTICLE</b>	<b>25A.</b>	<b>HEALTH</b>	<b>MAINTENANCE</b>	<b>ORGANIZATION</b>	<b>ACT.</b>
		<b>Mental</b>		<b>health</b>	<b>parity.</b>

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.