114CSR64

TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 64
MENTAL HEALTH PARITY

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SERIES 64
MENTAL HEALTH PARITY

§114-64-1. General.

1.1. Scope. – The purpose of this rule is to establish the requirements, process, and forms to be utilized by insurers and carriers to ensure the parity of benefits for behavioral health, mental health and substance use disorders with medical/surgical benefits and to ensure carrier compliance with W.Va. Code §§33-15-4u, 33-16-3ff, 33-24-7u, 33-25-8r, and 33-25A-8u. This rule applies to all health insurance policies, contracts, plans or agreements subject to Articles 15, 16, 24, 25, or 25A of Chapter 33 of the West Virginia Code that are delivered, executed, issued amended, adjusted, or renewed in this state on or after January 1, 2021.

1.2. Authority. – W. Va. Code §§33-2-10, 33-15-4u, 33-16-3ff, 33-24-7u, 33-25-8r, and 33-25A-8u.

1.3. Filing Date. – April 14, 2021.

1.4. Effective Date. – May 1, 2021.

1.5. Sunset Date. – This rule shall terminate and have no further force or effect upon August 1, 2026.

1.6. This legislative rule repeals and replaces 114CSR64 "Mental Health Parity" filed on April 14, 2010 and effective April 14, 2010.

§114-64-2. Definitions.

2.1. "Aggregate lifetime dollar limit" means, for the purposes of this rule, a dollar limitation on the total amount of specified benefits that may be paid under a health benefit plan, or health insurance coverage offered in connection with such a plan, for any coverage unit. Coverage unit refers to the way in which a plan, or health insurance coverage, groups individuals for purposes of determining benefits or premiums contributions, including family plans, employee with spouse plans, or individual plans.

2.2. "Annual dollar limit" means, for the purposes of this rule, a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a health benefit plan.

2.3. "Autism spectrum disorder" shall have the same meaning as defined at W.Va. Code §§33-16-3v, 33-24-7k, and 33-25A-8j, and includes any pervasive developmental disorder, including autistic disorder, Asperger's Syndrome, Rett syndrome, childhood disintegrative disorder, or Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

2.4. "Behavioral, mental health, and substance use disorder" shall have the same meaning as defined at W.Va. Code §§33-15-4u, 33-16-3ff, 33-24-7u, 33-25-8r, and 33-25A-8u, and shall mean 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 the International Statistical Classification of Diseases and Related Health Problems, the Diagnostic and Statistical Manual of Mental Disorders, or the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood; and includes Autism Spectrum Disorder.

2.5. "Behavioral, mental health, and substance use disorder benefits" means, for the purposes of this rule, the benefits supplied for items or services for behavioral, mental health or substance use disorder conditions.

2.6. "Carrier" shall mean any insurer offering an accident and sickness insurance policy, contract, plan or agreement subject to Articles 15, 16, 24, 25, or 25A of Chapter 33 of the West Virginia Code.

2.7. "Commissioner" means the West Virginia Insurance Commissioner.

2.8. "Concurrent review" means inpatient care is reviewed as it is provided.

2.9. "Financial requirements" means, for the purposes of this rule, the deductibles, copayments, coinsurance, or out-of-pocket maximums imposed under a health benefit plan. Financial requirements do not include aggregate lifetime or annual dollar limits.

2.10. "Health benefit plan" or "plan," as defined in W.Va. Code §33-16-1a(h), means benefits consisting of medical care provided directly, through insurance or reimbursement, or indirectly, including items and services paid for as medical care, under any hospital or medical expense incurred policy or certificate, hospital, medical or health service corporation contract, health maintenance organization contract, or plan provided by a multiple-employer trust or multiple-employer welfare arrangement. "Health benefit plan" does not include excepted benefits as defined by W. Va. Code §33-16-1a (f).

2.11. "Insurer" or "health insurer" means an insurer licensed to transact accident and sickness insurance in this state, and a health maintenance organization to whom a certificate of authority has been issued by the Commissioner and is subject to the provisions of Articles 15, 16, 24, 25, or 25A of Chapter 33 of the West Virginia Code, and is subject to the provisions of W.Va. Code §§33-15-4u, 33-16-3ff, 33-24-7u, 33-25-8r or 33-25A-8u.

2.12. "Medical/surgical benefits" means, for the purposes of this rule, the benefits supplied for items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law, but does not include behavioral, mental health, and substance use disorder benefits.

2.13. "Prior authorization" means obtaining advance approval from a carrier or insurer about the coverage of a benefit, service or medication.

2.14. "Substance use disorder" means the same as that term is defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders and shall include substance use withdrawal.

2.15. "Substance use disorder benefits" means, for the purposes of this rule, the benefits supplied for items or services used to treat substance use disorders, including substance use withdrawal.

2.16. "Treatment limitations" means, for the purposes of this rule, the limits applied based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically, and non-quantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. This term does not include any permanent exclusion of all benefits for a particular condition or disorder.

§114-64-3. Mental Health Parity and Required Coverage.

3.1. An insurer or carrier is required to provide coverage for the prevention of, screening for, and treatment of behavioral health, mental health, and substance use disorders that is no less extensive that the medical/surgical benefits or coverage provided for any physical illness and that complies with the requirements of this rule and with W.Va. Code §§33-15-4u, 33-16-3ff, 33-24-7u, 33-25-8r, or 33-25A-8u, whichever is applicable.

3.2. Screening for behavioral health, mental health, and substance use disorders shall include, but are not limited to, unhealthy alcohol use for adults, substance use for adults and adolescents, and depression screening for adults and adolescents.

3.3. An insurer or carrier that provides coverage for an annual physical examination shall include coverage for behavioral health screenings using a validated screening tool for behavioral health, which coverage and reimbursement is no less extensive than the coverage and reimbursement for the annual physical examination.

3.4. An insurer or carrier is required to establish procedures to authorize treatment with a non-participating provider if a covered service is not available within established time and distance standards as set forth in 114CSR100 and within a reasonable period after service is requested, and with the same coinsurance, deductible, or copayment requirements as would apply if the service were provided at a participating provider, and at no greater cost to the covered person than if the services were obtained at, or from a participating provider.

3.5. If a covered person obtains a covered service from a nonparticipating provider because the covered service is not available within the established time and distance standards as set forth in 114CSR100, an insurer or carrier is required to reimburse treatment or services for behavioral health, mental health, or substance use disorders that are provided by a non-participating provider using the same methodology that the insurer or carrier uses to reimburse covered medical/surgical services provided by non-participating providers and, upon request, provide evidence of the methodology to the person or provider.

3.6. An insurer or carrier offering a plan that does not cover services provided by an out-of-network provider may provide that the benefits required herein are covered benefits if the services are rendered by a provider who is designated by or affiliated with the insurer's or carrier's plan only if the same requirement applies for medical/surgical benefits or services. A carrier is not required to cover out-of-network care at one hundred percent (100%) or without any cost share to the covered person.

3.7. Subject to the limitation set forth in 3.8, nothing herein prohibits an insurer or carrier from using appropriate disease management or utilization review protocols for behavioral health, mental health, and substance use disorders, as long as the protocols are no more stringent or restrictive than medical/surgical disease management or utilization review protocols.

3.8. An insurer or carrier shall not impose any prior authorization or prospective utilization management requirements on any prescription medication on the insurer's or carrier's formulary that is used to treat substance use disorder when the medication is determined to be medically necessary by the covered person's provider.

3.9. If a health benefit plan, or health insurance coverage offered in connection with a plan, applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with requirements for non-quantitative treatment limitations, and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to behavioral, mental health, or substance use disorder benefits, the plan or carrier satisfies the parity requirements with respect to prescription drug benefits. Reasonable factors may include, but are not limited to, cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

§114-64-4. Financial Requirements and Quantitative Treatment Limitations.

4.1. An insurer or carrier shall comply with financial requirements and quantitative treatment limitations specified in 45 CFR §146.136(c)(2) and (c)(3), or any successor federal regulation as adopted by the Legislature through subsequent amendment to this rule.

4.2. An insurer or carrier shall not impose any financial requirement or quantitative treatment limitation on behavioral, mental health, or substance use disorder benefits that it does not impose on medical/surgical benefits.

4.3. An insurer or carrier shall not impose annual maximums on the number of visits or dollar amounts for behavioral, mental health, or substance use disorder benefits.

4.4. An insurer or carrier shall not impose any financial requirement or quantitative treatment limitation on behavioral, mental health, or substance use disorder benefits, unless the financial requirement or quantitative treatment limitation applies to substantially all of the medical/surgical benefits in a permitted benefit classification.

4.4.1. Benefit classifications may include:

4.4.1.a. Inpatient in-network;

4.4.1.b. Inpatient out-of-network;

4.4.1.c. Outpatient in-network, except that insurers or carriers may use the following sub-classifications;

4.4.1.c.1. Office visits, such as physician visits; and

4.4.1.c.2. All other outpatient services, such as outpatient surgery, day treatment centers, laboratory charges, or other medical items;

4.4.1.d. Outpatient out-of-network, except that insurers or carriers may use the following sub-classifications;

4.4.1.d.1. Office visits, such as physician visits; and

4.4.1.d.2. All other outpatient services, such as outpatient surgery, day treatment centers, laboratory charges, or other medical items;

4.4.1.e. Emergency; and

4.4.1.f. Pharmacy.

4.4.2. If an insurer or carrier provides benefits through multiple tiers of in-network providers, such as an in-network tier of preferred providers with more generous cost-sharing to members than a separate in-network tier of participating providers, the insurer or carrier may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the requirements in Section 5 of this rule and without regard to whether a provider provides services with respect to medical/surgical benefits or behavioral, mental health, and substance use disorder benefits.

4.4.3. After sub-classifications are established, the insurer or carrier shall not impose any financial requirement or treatment limitation on behavioral, mental health, and substance use disorder

benefits in any sub-classification that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology as required by sections 4.9 and 4.10 of this rule.

4.4.4. An insurer or carrier shall not use any other type of sub-classification, including but not limited to intermediate services, intensive care or any other sub-classification.

4.4.5. An insurer or carrier shall not sub-classify between primary care providers and specialists in the outpatient classifications.

4.5. An insurer or carrier shall not impose any financial requirement or quantitative treatment limitation on behavioral, mental health, or substance use disorder benefits that it does not impose on medical/surgical benefits.

4.6. An insurer or carrier shall not impose any financial requirement or quantitative treatment limitation on behavioral, mental health, or substance use disorder benefits, unless the financial requirement or quantitative treatment limitation applies to substantially all of the medical/surgical benefits in a permitted benefit classification, as shown in section 4.4 of this rule.

4.7. An insurer or carrier shall not impose a level of financial requirement or quantitative treatment limitation on behavioral, mental health, or substance use disorder benefits, unless the level of financial requirement or treatment limitation predominantly applies to medical/surgical benefits, as shown in Sections 4.9 and 4.10 of this rule.

4.8. Calculation of Substantially All and Predominant Level Tests

4.8.1. An insurer or carrier shall use a reasonable and verifiable method to determine the claims costs associated with the medical/surgical benefits that are subject to a financial requirement or quantitative treatment limitation. The method utilized by the carrier shall conform with Actuarial Standards of Practice.

4.8.2. An insurer or carrier shall not consider claims costs associated with behavioral, mental health, or substance use disorder benefits in the calculation.

4.8.3. An insurer or carrier shall consider all claims applying to the deductible and out-of-pocket maximum when calculating the deductible and out-of-pocket applicability in determining if the deductible and out-of-pocket apply to substantially all of the claims.

4.9. An insurer or carrier shall not use any financial requirement unless the insurer or carrier can provide verification that the following conditions have been met:

4.9.1. An insurer or carrier shall not apply any type of financial requirement or quantitative treatment limitation to behavioral, mental health, or substance use disorder benefits unless the financial requirement applies to “substantially all” medical/surgical benefits in a permitted classification, which consists of no less than two-thirds (2/3) of the expected medical/surgical claims for any given classification of benefits.

4.9.2. Once an insurer or carrier has determined that the financial requirement or quantitative treatment limitation applies to at least two-thirds (2/3) of the benefits, it shall not apply any specific level of financial requirement or quantitative treatment limitation to any behavioral, mental health, or substance use disorder benefit unless the financial requirement applies to more than one-half (1/2) of the expected claims for any given classification of benefits.

4.10. If, with respect to a financial requirement or quantitative treatment limitation that applies to at least two-thirds (2/3) of all medical/surgical benefits in a classification, an insurer or carrier determines

that no one specific level of financial requirement or quantitative treatment level applies to more than one-half (1/2) of the expected claims for the classification, the carrier may combine levels until the combination of levels applies to more than one-half (1/2) of the medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The carrier must use the least restrictive (lowest) amount that makes up one-half (1/2) of the expected claims.

4.11. An insurer or carrier shall use a combined deductible for behavioral, mental health, and substance use disorder and medical/surgical benefits.

4.12. An insurer or carrier shall use a combined out-of-pocket maximum for behavioral, mental health, and substance use disorder and medical/surgical benefits.

4.13. Nothing herein shall prohibit an insurer or carrier from providing some benefits that are subject to the deductible and other benefits that are not subject to the deductible within the same classification or from applying, separately, a deductible or out-of-pocket maximum that differs between the in-network and out-of-network benefit levels, as long as the same deductible or out-of-pocket applies to behavioral, mental health, or substance use disorder benefits that applies to medical/surgical benefits.

§114-64-5. Non-Quantitative Treatment Limitations.

5.1. An insurer or carrier shall comply with the non-quantitative treatment limitation requirements specified in 45 CFR §146.136(c)(4), or any successor regulation as adopted by the Legislature through subsequent amendment to this rule, regarding any limitations that are not expressed numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to the limitations and examples listed in 45 CFR §146.136(c)(4)(ii) and (c)(4)(iii), or any successor regulation, as adopted by the Legislature through subsequent amendment to this rule, and 78 FR 68246, include the methods by which the carrier establishes and maintains its provider network and responds to deficiencies in the ability of its networks to provide timely access to care.

5.2. An insurer or carrier shall not apply any non-quantitative treatment limitation to benefits for behavioral health, mental health, and substance use disorders that are not applied to medical/surgical benefits within the same classifications of benefits. Specifically, an insurer or carrier shall not impose a non-quantitative treatment limitation with respect to behavioral, mental health, and substance use disorder services in any classification unless, under the terms of the coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to behavioral, mental health, or substance use disorder services are comparable to, and are applied no more stringently than, the processes strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

5.3. Non-quantitative treatment limitations include, but are not limited to:

5.3.1. Medical management standards limiting or excluding benefits based on:

5.3.1.a. Medical necessity or medical appropriateness; or

5.3.1.b. Whether the treatment is experimental or investigational.

5.3.2. Step therapy or fail-first protocols;

5.3.3. Exclusions based on failure to complete a course of treatment;

5.3.4. Restrictions based on:

5.3.4.a. Geographic location;

5.3.4.b. Facility type;

5.3.4.c. Provider specialty; and

5.3.4.d. Other criteria that limit the scope or duration of benefits.

5.3.5. Formulary design for prescription drugs;

5.3.6. Network tier design (when the plan has multiple network tiers); and

5.3.7. Standards for provider admission to a network, including reimbursement rates.

5.4. Allowable Non-Quantitative Treatment Limitations

5.4.1. An insurer or carrier may utilize the following non-exhaustive standards when applying non-quantitative treatment limitations:

5.4.1.a. Medical management standards may be used, as long as the criteria are comparable, and applied no more stringently than for behavioral, mental health, and substance use disorder benefits than for medical/surgical benefits;

5.4.1.b. Formulary design or formulary management standards may be used, as long as the criteria used for behavioral, mental health, and substance use disorder benefits are comparable, and applied no more stringently than for medical/surgical benefits; and

5.4.1.c. Network design or network management standards to add or remove providers from the network may be used, as long as the criteria used for behavioral, mental health, and substance use disorder benefits are comparable, and applied no more stringently than for medical/surgical benefits that comply with state network adequacy requirements.

5.5. Non-Quantitative Treatment Limitation Prohibitions

5.5.1. Insurers or carriers shall not use the following medical management standards when applying limitations to behavioral, mental health, and substance use disorder benefits:

5.5.1.a. The insurer or carrier routinely approves a certain number of days without a treatment plan for medical/surgical inpatient services, but approves, on a routine basis, a lesser number of days without a treatment plan for inpatient behavioral, mental health, and substance use disorders.

5.5.1.b. The insurer or carrier applies concurrent review to inpatient stays with various lengths of stay due to the medical condition, but reviews all behavioral, mental health, and substance use disorder inpatient stays using a more restrictive review criteria, reviewing the stay more frequently in all cases than commonly used for medical/surgical benefits.

5.5.1.c. Location of Services

5.5.1.c.1. The insurer or carrier allows for out-of-state treatment of medical/surgical services, but does not permit out-of-state treatment for behavioral, mental health, and substance use disorder services; or

5.5.1.c.2. Permits access to a non-network hospital for medical/surgical services, but does not permit access to a non-network hospital for behavioral, mental health, and substance use disorders, when the plan covers non-network services.

5.5.1.d. The insurer or carrier does not apply a payment reduction penalty to outpatient medical/surgical services that do not have prior authorization, but applies a penalty to all outpatient behavioral, mental health, and substance use disorder benefits when no prior authorization has been obtained.

5.5.1.e. Employee Assistance Programs (Group Plans Only)

5.5.1.e.1. The insurer or carrier requires that the member utilize an Employee Assistance Program prior to utilizing behavioral, mental health, and substance use disorder benefits under a group plan, but does not require the member to utilize an Employee Assistance Program for any medical/surgical benefits prior to utilizing the group plan.

5.6. Insurers and carriers shall not use the following pharmacy benefit network designs when applying limitations to behavioral, mental health, and substance use disorder benefits:

5.6.1. Insurer or carrier formulary design for coverage of prescription drugs for medical/surgical conditions is based on FDA approval, clinical studies, peer-reviewed medical literature, recommendations of experts with necessary training and experience and other medical decision criteria which are routinely provided, whereas the exclusion of behavioral, mental health, and substance use disorder prescription drugs is only based on the side effects reported as a part of clinical studies.

5.6.2. An insurer or carrier regularly provides coverage for medical/surgical prescription drugs on all four (4) tiers of a four (4) tier formulary design, but places all prescription drugs for the treatment of behavioral, mental health, and substance use disorders on the two (2) highest tiers, without regard to it being generic, preferred brand name or non-preferred brand name.

5.7. Insurers or carriers shall not use the following network designs when applying limitations to behavioral, mental health, and substance use disorder benefits:

5.7.1. The insurer or carrier regularly allows licensed, non-M.D. providers into the network for medical/surgical benefits while not regularly allowing licensed, non-M.D. providers into the network who primarily treat behavioral, mental health, or substance use disorders.

5.7.2. The insurer or carrier regularly negotiates with medical/surgical providers based on the rates for behavioral, mental health, and substance use disorder providers.

§114-64-6. Concurrent Review and Denial of Benefits.

6.1. In the event of a concurrent review for a claim for coverage of services for the prevention of, screening for, and treatment of behavioral health, mental health, and substance use disorders, the insurer or carrier must continue to cover the service until the insurer or carrier notifies the covered person of the determination of the claim.

6.2. An insurer or carrier shall provide the covered person with written notice of a denial when denying benefits for the treatment of behavioral health, mental health, and/or substance use disorders that explicitly provides the reason for the denial.

6.3. Unless denied for nonpayment of premium, a denial of reimbursement for services for the prevention of, screening for, or treatment of behavioral health, mental health, and/or substance use disorders by the insurer or carrier must include the following language:

6.3.1. A statement explaining that covered persons are protected under state and federal law, which provides that limitations placed on the access to behavioral health, mental health, and/or substance use disorder benefits may be no greater than any limitations placed on access to medical/surgical benefits for physical illness or injury;

6.3.2. A statement providing that the covered person may contact the Consumer Services Division of the West Virginia Offices of the Insurance Commissioner if the covered person believes his or her rights under state or federal law have been violated. The statement should provide up-to-date contact information for the Consumer Services Division, including the current mailing address, toll-free telephone number, email address and website; and

6.3.3. A statement specifying that the covered person is entitled, upon request to the insurer or carrier, to a copy of the medical necessity criteria for any behavioral health, mental health, and substance use disorder benefit.

§114-64-7. Annual Reporting to the Commissioner.

7.1. As part of their annual health benefit plan filings, insurers or carriers shall provide an attestation to the commissioner that:

7.1.1. The plan applies the same deductible for medical/surgical and behavioral, mental health, and substance use disorders and does not otherwise apply any cumulative financial requirement for behavioral health, mental health, and substance use disorders in a classification that accumulates separately from any established for medical/surgical benefits in the same classification;

7.1.2. The plan applies the same out-of-pocket for medical/surgical and behavioral, mental health, and substance use disorders and does not otherwise apply any cumulative financial requirement for behavioral health, mental health, and substance use disorders in a classification that accumulates separately from any established for medical/surgical benefits in the same classification;

7.1.3. The plan uses the same benefits for emergency room benefits, including all ancillary services provided as part of the emergency room benefits, for medical/surgical and behavioral, mental health, and substance use disorders;

7.1.4. The plan utilizes the same copayment, coinsurance or deductible structure for prescription drug benefits for medical/surgical and behavioral, mental health, and substance use disorders;

7.1.5. The carrier utilizes the same penalties for failure to obtain prior authorization for behavioral, mental health, and substance use disorders as it does for medical/surgical procedures within the same classification of benefits.

7.2. The attestation shall be signed by responsible representative of the insurer or carrier, including but not limited to the president, vice president, assistant vice president, chief executive officer, chief financial officer, chief operating officer, general counsel or other person that has been appointed by the board of directors. The commissioner may develop an attestation form that the health carrier is required to use if he or she determines the attestation provided by the carrier is deficient or otherwise incomplete.

7.3. Data Reporting

7.3.1. Beginning on or after July 1, 2021, the commissioner shall issue annually a mandatory data call to all insurers or carriers subject to this rule to collect the following information for the commissioner's annual report on mental health parity to the Joint Committee on Government and Finance as required by the provisions of W.Va. Code §§33-15-4u, 33-16-3ff, 33-24-7u, 33-25-8r or 33-25A-8u.

7.3.2. The commissioner will develop a mechanism to accept the data from carriers electronically and securely. The insurers or carriers shall provide data for the twelve (12) month period immediately preceding the data call and shall only provide data regarding fully adjudicated claims, including any denied claims or adverse determinations.

7.3.3. The data call will, at a minimum, require the insurers or carriers to provide the following information and/or analysis to the commissioner.

7.3.3.a. Information regarding financial requirements and non-quantitative treatment limitations including data regarding:

7.3.3.a.1. Medical Management Evaluation;

7.3.3.a.2. Non-Quantitative Treatment Limitations;

7.3.3.a.3. Quantitative Treatment Limitation Classifications; and

7.3.3.a.4. Parity Compliance for Adverse Determinations, including the total number of adverse determinations of such claims.

7.3.3.b. Information regarding other non-quantitative treatment limitations including data regarding:

7.3.3.b.1. Inpatient In-Network;

7.3.3.b.2. Inpatient Out-of-Network;

7.3.3.b.3. Outpatient In-Network;

7.3.3.b.4. Outpatient Out-of-Network;

7.3.3.b.5. Emergency Room Services; and/or

7.3.3.b.6. Pharmacy Services.

7.4. Insurers or carriers may also be asked to provide specific information regarding processes for the development of medical necessity criteria or standards, eligibility criteria, concurrent review standards, non-quantitative treatment limitations or restrictions imposed upon obtaining covered services or benefits, processes, strategies and evidentiary standards, penalties that may be imposed for failure to obtain prior authorization for medical/surgical benefits compared to behavioral, mental health, and substance use disorder benefits.

7.5. The commissioner may ask that a qualified actuary certify that the calculations of the insurer or carrier are accurate and true to the best of the actuary's knowledge and have been appropriately calculated in accordance with Actuarial Standards of Practice.

§114-64-8. Comparative Analysis Reporting for Non-Quantitative Treatment Limitations.

8.1. An insurer or carrier shall provide annually to the Commissioner a comparative analysis demonstrating that, for any non-quantitative treatment limitation, including medical necessity criteria, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to benefits for behavioral, mental health, and substance use disorders within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits.

8.2. An insurer or carrier shall provide these comparative analyses results to the Commissioner, showing the following, at a minimum:

8.2.1. Identification of any factors used to determine whether a non-quantitative treatment limitation will apply to a benefit, including any factors considered but rejected;

8.2.2. Identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each non-quantitative treatment limitation;

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

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

8.2.5. Disclose the specific findings and conclusions reached by the insurer or carrier that the results of the analyses indicate that each health benefit plan offered by the insurer or carrier complies with W.Va. Code §§33-15-4u, 33-16-3ff, 33-24-7u, 33-25-8r or 33-25A-8u, whichever is applicable, and this rule.

8.3. The insurer or carrier shall provide the commissioner with its comparative analysis annually at the same time, and in conjunction with, the insurer's or carrier's response to the annual mental health parity data call refereed to in section 7 of this rule.

§114-64-9. Confidentiality.

9.1. The information and data obtained by the commissioner from an insurer or carrier under this rule shall be considered proprietary and confidential by law and privileged, exempt from disclosure pursuant to Chapter 29B of the West Virginia Code, confidential pursuant to W.Va. Code §§33-2-9 and 33-2-19, and is not open to public inspection, subject to subpoena, subject to discovery or admissible in evidence in any criminal, private civil or administrative action and is not subject to production pursuant to court order. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any investigation, regulatory action or legal action brought as part of the commissioner's official duties and to share information with other state or federal regulatory authorities as set forth in W.Va. Code §33-2-19.

§114-64-10. Enforcement.

10.1. Noncompliance with this rule may result, after proper notice and hearing, in the imposition of any of the sanctions made available to the Commissioner, including but not limited to, the imposition of monetary penalties, issuance of cease and desist orders, and/or suspensions or revocations of licenses or certificates of authority. Among others, the penalties provided for in W.Va. Code §§33-2-11 and 33-3-11 may be applied.