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HOUSE BILL NO. 656

Offered January 14, 2026

Prefiled January 13, 2026

A BILL to amend and reenact §§ 2.2-4006, 32.1-137.3, 32.1-276.7:1, and 38.2-3412.1 of the Code of Virginia, relating to mental health and substance abuse disorders; network adequacy standards; comparative analyses; report; emergency regulations.

Patron—Willett

Committee Referral Pending

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-4006, 32.1-137.3, 32.1-276.7:1, and 38.2-3412.1 of the Code of Virginia are amended and reenacted as follows:

§ 2.2-4006. Exemptions from requirements of this article.

A. The following agency actions otherwise subject to this chapter and § 2.2-4103 of the Virginia Register Act shall be exempted from the operation of this article:

1. Agency orders or regulations fixing rates or prices.

2. Regulations that establish or prescribe agency organization, internal practice or procedures, including delegations of authority.

3. Regulations that consist only of changes in style or form or corrections of technical errors. Each promulgating agency shall review all references to sections of the Code of Virginia within their regulations each time a new supplement or replacement volume to the Code of Virginia is published to ensure the accuracy of each section or section subdivision identification listed.

4. Regulations that are:

a. Necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. However, such regulations shall be filed with the Registrar within 90 days of the law's effective date;

b. Required by order of any state or federal court of competent jurisdiction where no agency discretion is involved; or

c. Necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation, and the Registrar has so determined in writing. Notice of the proposed adoption of these regulations and the Registrar's determination shall be published in the Virginia Register not less than 30 days prior to the effective date of the regulation.

5. Regulations of the Board of Agriculture and Consumer Services adopted pursuant to subsection B of § 3.2-3929 or clause (v) or (vi) of subsection C of § 3.2-3931 after having been considered at two or more Board meetings and one public hearing.

6. Regulations of (i) the regulatory boards served by the Department of Labor and Industry pursuant to Title 40.1 and the Department of Professional and Occupational Regulation or the Department of Health Professions pursuant to Title 54.1, (ii) the Board of Accountancy, and (iii) the State Board of Health that are limited to reducing fees charged to regulants and applicants.

7. The development and issuance of procedural policy relating to risk-based mine inspections by the Department of Energy authorized pursuant to §§ 45.2-560 and 45.2-1149.

8. General permits issued by the (a) State Air Pollution Control Board pursuant to Chapter 13 (§ 10.1-1300 et seq.) of Title 10.1 or (b) State Water Control Board pursuant to the State Water Control Law (§ 62.1-44.2 et seq.), Chapter 24 (§ 62.1-242 et seq.) of Title 62.1 and Chapter 25 (§ 62.1-254 et seq.) of Title 62.1, (c) Virginia Soil and Water Conservation Board pursuant to the Dam Safety Act (§ 10.1-604 et seq.), and (d) the development and issuance of general wetlands permits by the Marine Resources Commission pursuant to subsection B of § 28.2-1307, if the respective Board or Commission (i) provides a Notice of Intended Regulatory Action in conformance with the provisions of § 2.2-4007.01, (ii) following the passage of 30 days from the publication of the Notice of Intended Regulatory Action forms a technical advisory committee composed of relevant stakeholders, including potentially affected citizens groups, to assist in the development of the general permit, (iii) provides notice and receives oral and written comment as provided in § 2.2-4007.03, and (iv) conducts at least one public hearing on the proposed general permit.

9. The development and issuance by the Board of Education of guidelines on constitutional rights and restrictions relating to the recitation of the pledge of allegiance to the American flag in public schools pursuant to § 22.1-202.

10. Regulations of the Board of the Commonwealth Savers Plan adopted pursuant to § 23.1-704.

11. Regulations of the Marine Resources Commission.

12. Regulations adopted by the Board of Housing and Community Development pursuant to (i) Statewide Fire Prevention Code (§ 27-94 et seq.), (ii) the Industrialized Building Safety Law (§ 36-70 et seq.), (iii) the Uniform Statewide Building Code (§ 36-97 et seq.), and (iv) § 36-98.3, provided the Board (a) provides a Notice of Intended Regulatory Action in conformance with the provisions of § 2.2-4007.01, (b) publishes the proposed regulation and provides an opportunity for oral and written comments as provided in § 2.2-4007.03, and (c) conducts at least one public hearing as provided in §§ 2.2-4009 and 36-100 prior to the publishing of the proposed regulations. Notwithstanding the provisions of this subdivision, any regulations promulgated by the Board shall remain subject to the provisions of § 2.2-4007.06 concerning public petitions, and §§ 2.2-4013 and 2.2-4014 concerning review by the Governor and General Assembly.

13. Amendments to regulations of the Board to schedule a substance pursuant to subsection D or E of § 54.1-3443.

14. Waste load allocations adopted, amended, or repealed by the State Water Control Board pursuant to the State Water Control Law (§ 62.1-44.2 et seq.), including but not limited to Article 4.01 (§ 62.1-44.19:4 et seq.) of the State Water Control Law, if the Board (i) provides public notice in the Virginia Register; (ii) if requested by the public during the initial public notice 30-day comment period, forms an advisory group composed of relevant stakeholders; (iii) receives and provides summary response to written comments; and (iv) conducts at least one public meeting. Notwithstanding the provisions of this subdivision, any such waste load allocations adopted, amended, or repealed by the Board shall be subject to the provisions of §§ 2.2-4013 and 2.2-4014 concerning review by the Governor and General Assembly.

15. Regulations of the Workers' Compensation Commission adopted pursuant to § 65.2-605, including regulations that adopt, amend, adjust, or repeal Virginia fee schedules for medical services, provided the Workers' Compensation Commission (i) utilizes a regulatory advisory panel constituted as provided in subdivision F 2 of § 65.2-605 to assist in the development of such regulations and (ii) provides an opportunity for public comment on the regulations prior to adoption.

16. Amendments to the State Health Services Plan adopted by the Board of Health following receipt of recommendations by the State Health Services Task Force pursuant to § 32.1-102.2:1 if the Board (i) provides a Notice of Intended Regulatory Action in accordance with the requirements of § 2.2-4007.01, (ii) provides notice and receives comments as provided in § 2.2-4007.03, and (iii) conducts at least one public hearing on the proposed amendments.

17. Rules of the Workers' Compensation Commission adopted pursuant to subsection A of § 65.2-201 and subsection B of § 65.2-703, provided the Workers' Compensation Commission provides an opportunity for public comment on the rules prior to adoption.

18. Amendments to the network adequacy standards for a managed care health insurance plan adopted by the Board of Health that conform to the network adequacy standards required for qualified health plans and qualified dental plans, as such terms are defined in § 38.2-6500, offered in the Commonwealth, provided that the Board provides an opportunity for public comment on such amendments prior to adoption.

B. Whenever regulations are adopted under this section, the agency shall state as part thereof that it will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision. The effective date of regulations adopted under this section shall be in accordance with the provisions of § 2.2-4015, except in the case of emergency regulations, which shall become effective as provided in subsection B of § 2.2-4012.

C. A regulation for which an exemption is claimed under this section or § 2.2-4002 or 2.2-4011 and that is placed before a board or commission for consideration shall be provided at least two days in advance of the board or commission meeting to members of the public that request a copy of that regulation. A copy of that regulation shall be made available to the public attending such meeting.

§ 32.1-137.3. Regulations.

Consistent with its duties to protect the health, safety, and welfare of the public, the Board shall promulgate regulations, consistent with this article, governing the quality of care provided to covered persons by a managed care health insurance plan licensee through its managed care health insurance plans on or before December 1, 1999. The regulations may incorporate or apply nationally recognized, generally accepted, quality standards developed by private accreditation entities, if such standards exist and as appropriate for the type of managed care health insurance plan. The regulations shall also include ~~guidelines~~*:*

1. Guidelines for the Commissioner to determine, in consultation with the Bureau of Insurance, when the imposition of administrative sanctions as set forth in § 32.1-137.5 or initiation of court proceedings or both are appropriate in order to ensure prompt correction of violations discovered on any examination, review, or investigation conducted by the Department pursuant to provisions of this article*; and*

2. Quantitative network adequacy standards for timely access to care, travel time, and geographical distance that are at least as stringent as those required for qualified health plans and qualified dental plans, as such terms are defined in § 38.2-6500, provided in the Commonwealth.

§ 32.1-276.7:1. All-Payer Claims Database created; purpose; reporting requirements.

A. The Virginia All-Payer Claims Database is hereby created to facilitate data-driven, evidence-based improvements in access, quality, and cost of health care and to promote and improve the public health

through the understanding of health care expenditure patterns and operation and performance of the health care system.

B. The Commissioner shall ensure that the Department meets the requirements to be a health oversight agency as defined in 45 C.F.R. § 164.501.

C. The Commissioner, in cooperation with the Bureau of Insurance, shall collect ~~paid~~ claims data ~~for covered benefits~~ from data suppliers, which shall include:

1. Issuers of individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; corporations providing individual or group accident and sickness subscription contracts; and health maintenance organizations providing a health care plan for health care services, for at least 1,000 covered lives in the most recent calendar year;

2. Third-party administrators and any other entities that receive or collect charges, contributions, or premiums for, or adjust or settle health care claims for, at least 1,000 Virginia covered lives on behalf of group health plans other than ERISA plans;

3. Third-party administrators, and any other entities, that receive or collect charges, contributions, or premiums for, or adjust or settle health care claims for, an employer that maintains an ERISA plan that has opted-in to data submission to the All-Payer Claims Database pursuant to subsection P;

4. The Department of Medical Assistance Services with respect to services provided under programs administered pursuant to Titles XIX and XXI of the Social Security Act;

5. State government health insurance plans;

6. Local government health insurance plans, subject to their ability to provide such data and to the extent permitted by state and federal law; and

7. Federal health insurance plans, to the extent permitted by federal law, including Medicare, TRICARE, and the Federal Employees Health Benefits Plan.

Such collection of ~~paid~~ claims data ~~for covered benefits~~ shall not include data related to Medigap, disability income, workers' compensation claims, standard benefits provided by long-term care insurance, disease specific health insurance, dental or vision claims, or other supplemental health insurance products;

D. The Commissioner shall ensure that the nonprofit organization executes a standard data submission and use agreement with each entity listed in subsection B that submits ~~paid~~ claims data to the All-Payer Claims Database and each entity that subscribes to data products and reports. Such agreements shall include procedures for submission, collection, aggregation, and distribution of specified data. Additionally, the Commissioner shall ensure that the nonprofit organization:

1. Protects patient privacy and data security pursuant to provisions of this chapter and state and federal privacy laws, including the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq., as amended); Titles XIX and XXI of the Social Security Act; § 32.1-127.1:03; Chapter 6 (§ 38.2-600 et seq.) of Title 38.2; and the Health Information Technology for Economic and Clinical Health (HITECH) Act, as included in the American Recovery and Reinvestment Act (P.L. 111-5, 123 Stat. 115) as if the nonprofit organization were covered by such laws;

2. Identifies the type of ~~paid~~ claims to be collected by the All-Payer Claims Database and the entities that are subject to the submission of such claims as well as identification of specific data elements from existing claims systems to be submitted and collected, including but not limited to patient demographics, diagnosis and procedure codes, provider information, plan payments, member payment responsibility, and service dates;

3. Administers the All-Payer Claims Database in a manner to allow for geographic, demographic, economic, and peer group comparisons;

4. Develops public analyses identifying and comparing health plans by public and private health care purchasers, providers, employers, consumers, health plans, health insurers, and data analysts, health insurers, and providers with regard to their provision of safe, cost-effective, and high-quality health care services;

5. Uses common data layout or other national data collection standards and methods that utilize a standard set of core data elements for data submissions, as adopted or endorsed by the APCD Council, to establish and maintain the database in a cost-effective manner and to facilitate uniformity among various all-payer claims databases of other states and specification of data fields to be included in the submitted claims, consistent with such national standards, allowing for exemptions when submitting entities do not collect the specified data or pay on a per-claim basis, such exemption process to be managed by the advisory committee created pursuant to subsection E;

6. Does not disclose or report provider-specific, facility-specific, or carrier-specific reimbursement information, or information capable of being reverse-engineered, combined, or otherwise used to calculate or derive such reimbursement information, from the All-Payer Claims Database;

7. Promotes the responsible use of claims data to improve health care value and preserve the integrity and utility of the All-Payer Claims Database; and

8. Requires that all public reports and analyses comparing providers or health plans using data from the All-Payer Claims Database use national standards or, when such national standards are unavailable, provide full transparency to providers or health plans of the alternative methodology used.

E. The Commissioner shall establish an advisory committee to assist in the formation and operation of the All-Payer Claims Database. Such committee shall consist of (i) a representative from each of the following: a statewide hospital association, a statewide association of health plans, a professional organization representing physicians, a professional organization representing pharmacists, an organization that processes insurance claims or certain aspects of employee benefits plans for a separate entity, a community mental health center who has experience in behavioral health data collection, a nursing home health care provider who has experience with medical claims data, a nonprofit health insurer, and a for-profit health insurer; (ii) up to two representatives with a demonstrated record of advocating health care issues on behalf of consumers; (iii) two representatives of hospitals or health systems; (iv) an individual with academic experience in health care data and cost-efficiency research; (v) a representative who is not a supplier or broker of health insurance from small employers that purchase group health insurance for employees; (vi) a representative who is not a supplier or broker of health insurance from large employers that purchase health insurance for employees, and (vii) a representative who is not a supplier or broker of health insurance from self-insured employers, all of whom shall be appointed by the Commissioner. The Commissioner, the chairman of the board of directors of the nonprofit organization, the Commissioner of Insurance, the Director of the Department of Medical Assistance Services, the Director of the Department of Human Resource Management, or their designees, shall serve ex officio.

In appointing members to the advisory committee, the Commissioner shall adopt reasonable measures to select representatives in a manner that provides balanced representation within and among the appointments and that any representative appointed is without any actual or apparent conflict of interest, including conflicts of interest created by virtue of the individual's employer's corporate affiliations or ownership interests.

The nonprofit organization shall provide the advisory committee with details at least annually on the use and disclosure of All-Payer Claims Database data, including reports developed by the nonprofit organization; details on methods used to extract, transform, and load data; and efforts to protect patient privacy and data security.

The meetings of the advisory committee shall be open to the public.

F. The Commissioner shall establish a data release committee to review and approve requests for access to data. The data release committee shall consist of the Commissioner or his designee, and upon recommendation of the advisory committee, the Commissioner shall appoint an individual with academic experience in health care data and cost-efficiency research; a representative of a health insurer; a health care practitioner; a representative from a hospital with a background in administration, analytics, or research; and a representative with a demonstrated record of advocating health care issues on behalf of consumers. In making its recommendations, the advisory committee shall adopt reasonable measures to select representatives in a manner that provides balanced representation within and among the appointments and that any representative appointed is without any actual or apparent conflict of interest, including conflicts of interest created by virtue of the individual's employer's corporate affiliations or ownership interests. The data release committee shall ensure that (i) all data approvals are consistent with the purposes of the All-Payer Claims Database as provided in subsection A; (ii) all data approvals comply with applicable state and federal privacy laws and state and federal laws regarding the exchange of price and cost information to protect the confidentiality of the data and encourage a competitive marketplace for health care services; and (iii) the level of detail, as provided in subsection H, is appropriate for each request and is accompanied by a standardized data use agreement.

G. The nonprofit organization shall implement the All-Payer Claims Database, consistent with the provisions of this chapter, to include:

1. The reporting of data that can be used to improve public health surveillance and population health, including reports on (i) injuries; (ii) chronic diseases, including but not limited to asthma, diabetes, cardiovascular disease, hypertension, arthritis, and cancer; (iii) health conditions of pregnant women, infants, and children; and (iv) geographic and demographic information for use in community health assessment, prevention education, and public health improvement. This data shall be developed in a format that allows comparison of information in the All-Payer Claims Database with other nationwide data programs and that allows employers to compare their employee health plans statewide and between and among regions of the Commonwealth and nationally.

2. The reporting of data that payers, providers, and health care purchasers, including employers and consumers, may use to compare quality and efficiency of health care, including development of information on utilization patterns and information that permits comparison of health plans and providers statewide between and among regions of the Commonwealth. The advisory committee created pursuant to subsection E shall make recommendations to the nonprofit organization on the appropriate level of specificity of reported data in order to protect patient privacy and to accurately attribute services and resource utilization rates to providers.

3. The reporting of data that permits design and evaluation of alternative delivery and payment models.

4. The reporting and release of data consistent with the purposes of the All-Payer Claims Database as set

forth in subsection A as determined to be appropriate by the data release committee created pursuant to subsection F.

H. Except as provided in subsection O, the nonprofit organization shall not provide data or access to data without the approval of the data release committee. Upon approval, the nonprofit organization may provide data or access to data at levels of detail that may include (i) aggregate reports, which are defined as data releases with all observation counts greater than 10; (ii) de-identified data sets that meet the standard set forth in 45 C.F.R. § 164.514(a); and (iii) limited data sets that comply with the National Institutes of Health guidelines for release of personal health information.

I. Reporting of data shall not commence until such data has been processed and verified at levels of accuracy consistent with existing nonprofit organization data standards. Prior to public release of any report specifically naming any provider or payer, or public reports in which an individual provider or payers represents 60 percent or more of the data, the nonprofit organization shall provide affected entities with notice of the pending report and allow for a 30-day period of review to ensure accuracy. During this period, affected entities may seek explanations of results and correction of data that they prove to be inaccurate. The nonprofit organization shall make these corrections prior to any public release of the report. At the end of the review period, upon completion of all necessary corrections, the report may be released. For the purposes of this subsection, "public release" means the release of any report to the general public and does not include the preparation of reports for, or use of the All-Payer Claims Database by, organizations that have been approved for access by the data release committee and have entered into written agreements with the nonprofit organization.

J. The Commissioner and the nonprofit organization shall consider and recommend, as appropriate, integration of new data sources into the All-Payer Claims Database, based on the findings and recommendations of the advisory committee.

K. Information acquired pursuant to this section shall be confidential and shall be exempt from disclosure by the Virginia Freedom of Information Act (§ 2.2-3700 et seq.). The reporting and release of data pursuant to this section shall comply with all state and federal privacy laws and state and federal laws regarding the exchange of price and cost information to protect the confidentiality of the data and encourage a competitive marketplace for health care services.

L. No person shall assess costs or charge a fee to any health care practitioner related to formation or operation of the All-Payer Claims Database. However, a reasonable fee may be charged to health care practitioners who voluntarily access the All-Payer Claims Database for purposes other than data verification.

M. As used in this section, "provider" means a hospital or physician as defined in this chapter or any other health care practitioner licensed, certified, or authorized under state law to provide covered services represented in claims reported pursuant to this section.

N. The Commissioner, in consultation with the board of directors of the nonprofit organization, shall develop short-term and long-term funding strategies for the operation of the All-Payer Claims Database to provide necessary funding in excess of any budget appropriation by the Commonwealth.

O. The nonprofit organization, the Department of Health, the Department of Medical Assistance Services, and the Bureau of Insurance shall have access to data reported by the All-Payer Claims Database pursuant to this section at no cost for the purposes of public health improvement research and activities.

P. Each employer that maintains an ERISA plan may opt-in to allow a third-party administer or other entity to submit data to the All-Payer Claims Database. For any such employer that opts-in, the third-party administrator or other entity shall (i) submit data for the next reporting period after the opt-in and all future reporting periods until the employer opts-out and (ii) include data from any such employer as part of its data submission, if any, otherwise required by this section. Such an employer may opt-out at any time but shall provide written notice to the third-party administrator or other entity of its decision at least 30 days prior to the start of the next reporting period. No employer that maintains an ERISA plan shall be required to opt-in to data submission to the All-Payer Claims Database, and no third-party administrator or other entity shall be required to submit claims processed before it was contracted to provide services. Each third-party administrator or other entity providing claim administration services for an employer shall submit annually to the nonprofit organization by January 31 of each year a list of the ERISA plans whose employer has opted-in to data submission to the All-Payer Claims Database and a list identifying all employers that maintain an ERISA plan with Virginia employees for which it provides claim administration services. Such information submitted shall be considered proprietary and shall be exempt from disclosure by the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

Q. Any data release shall make use of a masked proxy reimbursement amount, for which the methodology is publicly available and approved by the data release committee except that the Department may request that the nonprofit organization generate the following reports based on actual reimbursement amounts: (i) the total cost burden of a disease, chronic disease, injury, or health condition across the state, health planning region, health planning district, county, or city, provided that the total cost shall be an aggregate amount encompassing costs attributable to all data suppliers and not identifying or attributable to any individual provider, and (ii) any analyses to determine the average reimbursement that is paid for health care services

that may include inpatient and outpatient diagnostic services, surgical services or the treatment of certain conditions or diseases. Any additional report of analysis based on actual reimbursement amounts shall require the approval of the data release committee.

R. The nonprofit organization shall ensure the timely reporting of information by private data suppliers to meet the requirements of this section. The nonprofit organization shall notify private data suppliers of any applicable reporting deadlines. The nonprofit shall notify, in writing, a private data supplier of a failure to meet a reporting deadline, and that failure to respond within two weeks following receipt of the written notice may result in a penalty. The Board may assess a civil penalty of up to $1,000 per week per violation, not to exceed a total of $50,000 per violation, against a private data supplier that fails, within its determination, to make a good faith effort to provide the requested information within two weeks following receipt of the written notice required by this subsection. Civil penalties assessed under this subsection shall be maintained by the Department and used for the ongoing improvement of the All-Payer Claims Database.

§ 38.2-3412.1. Coverage for mental health and substance use disorders.

A. As used in this section:

"Adult" means any person who is 19 years of age or older.

"Alcohol or drug rehabilitation facility" means a facility in which a state-approved program for the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State Board of Health pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the Department of Behavioral Health and Developmental Services pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2 or (ii) a state agency or institution.

"Child or adolescent" means any person under the age of 19 years.

"Crisis receiving center" means a community-based facility licensed by the Department of Behavioral Health and Developmental Services to provide short-term assessment, observation, and crisis stabilization services.

"Generally accepted standards of mental health or substance use disorder care" means evidence-based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties including child and adolescent psychiatry, adult psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Sources reflecting "generally accepted standards of mental health or substance use disorder care" include peer-reviewed scientific studies and medical literature, consensus guidelines and recommendations of nonprofit health care provider professional associations and specialty societies, and nationally recognized clinical practice guidelines, including patient placement criteria, service intensity assessment instruments, clinical practice guidelines, guidelines and recommendations of federal government agencies, and drug labeling approved by the U.S. Food and Drug Administration. Nothing in this section shall supersede the standard of care as set forth in § 8.01-581.20.

"Inpatient treatment" means mental health or substance abuse services delivered on a 24-hour per day basis in a hospital, alcohol or drug rehabilitation facility, an intermediate care facility or an inpatient unit of a mental health treatment center.

"Intermediate care facility" means a licensed, residential public or private facility that is not a hospital and that is operated primarily for the purpose of providing a continuous, structured 24-hour per day, state-approved program of inpatient substance abuse services.

"Medically necessary" means, with respect to the treatment of a mental health or substance use disorder, a service or product addressing the specific needs of a patient for the purpose of screening, preventing, diagnosing, managing, or treating such disorder, including minimizing the progression of such disorder, in a manner that is in accordance with generally accepted standards of mental health or substance use disorder care; clinically appropriate in terms of type, frequency, extent, site, and duration; and not defined primarily for the economic benefit of an insurer or purchaser or for the convenience of the patient, treating physician, or other health care provider.

"Medication management visit" means a visit no more than 20 minutes in length with a licensed physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance abuse treatment.

"Mental health services" or "mental health benefits" means *services or* benefits ~~with respect to items or services for mental health conditions as defined under the terms of the health benefit plan. Any condition defined by the health benefit plan as being or as not being a mental health condition shall be defined to be consistent with generally recognized independent standards of current medical practice~~ *for all conditions covered under the health insurance plan or coverage, except for substance use disorders, that fall under the diagnostic categories listed in the Mental, Behavioral, and Neurodevelopmental Disorders chapter, or equivalent chapter, of the most current version of the International Classification of Diseases of the Word Health Organization or in the most current version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.*

"Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored

by a physician, clinical psychologist, or a psychologist licensed to practice in this Commonwealth. The facility shall be (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

"Mobile crisis response services" means services licensed by the Department of Behavioral Health and Developmental Services to provide for rapid response to, assessment of, and early intervention for individuals experiencing an acute mental health crisis that are deployed at the location of the individual.

"Network adequacy" means access to services by measure of distance, time, and average length of referral to scheduled visit.

"Outpatient treatment" means mental health or substance abuse treatment services rendered to a person as an individual or part of a group while not confined as an inpatient. Such treatment shall not include services delivered through a partial hospitalization or intensive outpatient program as defined herein.

"Partial hospitalization" means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

"Residential crisis stabilization unit" means a community-based, short-term residential program licensed by the Department of Behavioral Health and Developmental Services to provide short-term assessment, observation, support, and crisis stabilization for individuals who are experiencing an acute mental health crisis.

"Substance abuse services" or "substance use disorder benefits" means *services or* benefits ~~with respect to items or services for substance use disorders as defined under the terms of the health benefit plan. Any disorder defined by the health benefit plan as being or as not being a substance use disorder shall be defined to be consistent with generally recognized independent standards of current medical practice~~ *for all conditions covered under the health insurance plan or coverage, except for medical and surgical or mental health conditions, that fall under the diagnostic categories for substance use disorders in the Mental, Behavioral, and Neurodevelopmental Disorders chapter, or equivalent chapter, of the most current version of the International Classification of Diseases of the World Health Organization or in the Substance-Related and Addictive Disorders section, or equivalent section, of the most current version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.*

"Treatment" means services including diagnostic evaluation, medical, psychiatric and psychological care, and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence rendered by a hospital, alcohol or drug rehabilitation facility, intermediate care facility, mental health treatment center, a physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed substance abuse treatment practitioner, licensed marriage and family therapist or clinical nurse specialist. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified alcoholism, drug, or substance abuse counselor or substance abuse counseling assistant, limited to the scope of practice set forth in § 54.1-3507.1 or 54.1-3507.2, respectively, employed by a facility or program licensed to provide such treatment.

B. Except as provided in subsections C and D, group and individual health insurance coverage, as defined in § 38.2-3431, shall provide coverage for mental health and substance use disorder benefits for children, adolescents, and adults. Such benefits shall be in parity with the medical and surgical benefits contained in the coverage in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), P.L. 110-343, even where those requirements would not otherwise apply directly, and shall apply the definitions of "generally accepted standards of mental health or substance use disorder care" and "medically necessary" provided in subsection A for any determination of medical necessity, prior authorization, or utilization review under such coverage. In conducting utilization review involving decisions within the scope of generally accepted standards of mental health or substance use disorder care, no insurer providing such coverage shall apply criteria that are different from, additional to, conflicting with, or more restrictive than the criteria set forth in such generally accepted standards. Coverage required under this subsection shall include mobile crisis response services and support and stabilization services provided in a residential crisis stabilization unit or crisis receiving center to the extent that such services are covered in other settings or modalities, regardless of any difference in billing codes. *The Commission may promulgate regulations as necessary to implement the provisions of this subsection, including by adopting or incorporating, in whole or in part, federal regulations related to implementing the Mental Health Parity and Addiction Equity Act as published in 89 Fed. Reg. 77735–77751 on September 23, 2024.*

C. Any grandfathered plan as defined in § 38.2-3438 in the small group market shall either continue to

provide benefits in accordance with subsection B or continue to provide coverage for inpatient and partial hospitalization mental health and substance abuse services as follows:

1. Treatment for an adult as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of 20 days per policy or contract year.

2. Treatment for a child or adolescent as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of 25 days per policy or contract year.

3. Up to 10 days of the inpatient benefit set forth in subdivisions 1 and 2 of this subsection may be converted when medically necessary at the option of the person or the parent, as defined in § 16.1-336, of a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage. An insurance policy or subscription contract described herein that provides inpatient benefits in excess of 20 days per policy or contract year for adults or 25 days per policy or contract year for a child or adolescent may provide for the conversion of such excess days on the terms set forth in this subdivision.

4. The limits of the benefits set forth in this subsection shall not be more restrictive than for any other illness, except that the benefits may be limited as set out in this subsection.

5. This subsection shall not apply to any excepted benefits policy as defined in § 38.2-3431, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

D. Any grandfathered plan as defined in § 38.2-3438 in the small group market shall also either continue to provide benefits in accordance with subsection B or continue to provide coverage for outpatient mental health and substance abuse services as follows:

1. A minimum of 20 visits for outpatient treatment of an adult, child or adolescent shall be provided in each policy or contract year.

2. The limits of the benefits set forth in this subsection shall be no more restrictive than the limits of benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit beyond the first five of such visits covered in any policy or contract year shall be at least 50 percent.

3. For the purpose of this ~~section~~ *subsection*, medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of the benefit set forth herein.

4. For the purpose of this subsection, if all covered expenses for a visit for outpatient mental health or substance abuse treatment apply toward any deductible required by a policy or contract, such visit shall not count toward the outpatient visit benefit maximum set forth in the policy or contract.

5. This subsection shall not apply to any excepted benefits policy as defined in § 38.2-3431, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

E. *1. Each health carrier shall submit to the Bureau, on the date and frequency as specified by the Bureau, which shall be no less frequently than every two years, all comparative analyses prepared by the carrier pursuant to 42 U.S.C. § 300gg-26(a)(8). The Bureau shall make current comparative analyses publicly available. Publication of the comparative analyses or information linked on the Commission's website shall not constitute approval or a determination of compliance by the Bureau. The Bureau may require a health carrier to provide supplementary data as the Bureau deems relevant for the purposes of evaluating a comparative analysis.*

2. With respect to a comparative analysis prepared by a carrier pursuant to 42 U.SC. § 300gg-26(a)(8), the Bureau shall request the following quantitative data for medical and surgical benefits, mental health benefits, and substance use disorder benefits:

a. The number and percentage of denied claims, prior authorizations, concurrent reviews, and retrospective reviews;

b. The number and percentage of complaints and appeals, including reasons for complaints and outcomes of appeals;

c. The number and percentage of out-of-network claims;

d. The frequency and number of prior authorizations, concurrent reviews, and retrospective reviews;

e. Reimbursement rates, by provider type, benchmarked to a national standard, billed amount, or other basis;

f. The number and percentage of insured individuals for whom the quantitative network adequacy standards were met;

g. The average and median number of days to approve or deny a credentialing application;

h. Metrics regarding the timeliness of updating provider directories upon the addition of a new provider or the termination of a provider contract and the number of providers in the directory accepting new patients;

i. The number and percentage of providers of each specialty who received reimbursement; and

j. Other quantitative data that the Bureau may require.

3. Based on an initial review of comparative analyses and supplementary data, the Bureau may initiate a market conduct examination pursuant to § 38.2-1317.1 or evaluate compliance regarding the federal Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and state mental health or substance use disorder requirements.

4. A noncompliant or insufficient comparative analysis shall constitute a violation of this subsection. In addition to the authority granted to the Bureau under this title, the Bureau may:

a. Impose a penalty not to exceed $100,000 per each violation of this subsection;

b. Require a carrier to remove a noncompliant non-quantitative treatment limitation, as defined in 42 U.SC. § 300gg-26(a)(8); or

c. Require a carrier to revise or otherwise remedy noncompliant portions of a non-quantitative treatment limitation, as defined in 42 U.SC. § 300gg-26(a)(8).

F. The requirements of this section shall apply to all insurance policies and subscription contracts delivered, issued for delivery, reissued, renewed, or extended, or at any time when any term of the policy or contract is changed or any premium adjustment made.

~~F.~~ *G.* The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

~~G.~~ *H.* ~~The Bureau of Insurance, in consultation with health carriers providing coverage for mental health and substance use disorder benefits pursuant to this section, shall develop reporting requirements regarding denied claims, complaints, appeals, and network adequacy involving such coverage set forth in this section. By November~~ *Beginning in 2027, by December* 1 of each *odd-numbered* year, the Bureau shall ~~compile the information for the preceding year into a report that ensures the confidentiality of individuals whose information has been reported and is written in nontechnical, readily understandable language. The Bureau shall include in the report~~ *submit* a summary of ~~all comparative analyses prepared by health carriers pursuant to 42 U.S.C. § 300gg-26(a)(8) that the Bureau requested during the reporting period~~ *enforcement efforts with respect to the federal Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and state requirements for mental health and substance abuse services and benefits.* This summary shall include ~~the Bureau's explanation of whether the analyses were accepted as compliant, rejected as noncompliant, or are in process of review. For analyses that were noncompliant, the report shall include the corrective actions that the Bureau required the health carrier to take to come into compliance~~ *any patterns identified in the comparative analyses submitted, supplementary data collected, or market conduct examination or compliance evaluation, to the extent that such information can be disclosed.* The Bureau shall make the report available to the public by, among such other means as the Bureau finds appropriate, posting the reports on the Bureau's website and submit the report to the *Chairs of the* House Committee on Labor and Commerce and the Senate Committee on Commerce and Labor.

2. That no later than October 1, 2026, each health carrier subject to the provisions of this act shall submit to the Bureau of Insurance all comparative analyses prepared by the health carrier pursuant to 42 U.S.C. §§ 300gg-26(a)(8) and information on how to publicly access such information online.

3. That the Board of Health shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment to establish quantitative network adequacy standards for timely access to care, travel time, and geographic distance that are at least as stringent as those imposed by the Virginia Health Benefits Exchange for qualified health plans and qualified dental plans, pursuant to § 32.1-137.3 of the Code of Virginia, as amended by this act.