WEST VIRGINIA CODE CHAPTER 5 ARTICLE 16

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§5-16-1. Short title; legislative intent.

The short title by which this article may be referred to is "West Virginia Public Employees Insurance Act" and it is the express intent of the Legislature to encourage and promote a uniform partnership relation between all employers and employees participating in the insurance plan or plans formulated under the provisions of this article and constituting the insurance program, and to hereby declare such insurance program to be for a public purpose.

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§5-16-2. Definitions.

The following words and phrases as used in this article, unless a different meaning is clearly indicated by the context, have the following meanings:

"Agency" or "PEIA" means the Public Employees Insurance Agency created by this article.

"Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences in order to produce socially significant improvement in human behavior and includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Autism spectrum disorder" means 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.

"Certified behavior analyst" means an individual who is certified by the Behavior Analyst Certification Board or certified by a similar nationally recognized organization.

"Dependent" includes an eligible employee's child under the age of 26 as defined in the Patient Protection and Affordable Care Act.

"Device" means a blood glucose test strip, glucometer, continuous glucose monitor (CGM), lancet, lancing device, or insulin syringe used to cure, diagnose, mitigate, prevent, or treat diabetes or low blood sugar, but does not include insulin pumps.

"Director" means the Director of the Public Employees Insurance Agency created by this article.

"Distant site" means the telehealth site where the health care practitioner is seeing the patient at a distance or consulting with a patient's health care practitioner.

"Employee" means any person, including an elected officer, who works regularly full-time in the service of the State of West Virginia; and, for the purpose of this article only, the term "employee" also means any person, including an elected officer, who works regularly full-time in the service of a county board of education; a public charter school established pursuant to §18-5G-1 *et seq*. of this code if the charter school includes in its charter contract entered into pursuant to §18-5G-7 of this code a determination to participate in the Public Employees Insurance program; a county, city, or town in the state; any separate corporation or instrumentality established by one or more counties, cities, or towns, as permitted by law; any corporation or instrumentality supported in most part by counties, cities, or towns; any public corporation charged by law with the performance of a governmental function and whose jurisdiction is coextensive with one or more counties, cities, or towns; any comprehensive community mental health center or intellectually and developmentally

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disabled facility established, operated, or licensed pursuant to §27-2A-1 of this code and which is supported in part by state, county, or municipal funds; any person who works regularly full-time in the service of the Higher Education Policy Commission, the West Virginia Council for Community and Technical College Education, or a governing board as defined in §18B-1-2 of this code; any person who works regularly full-time in the service of a combined city-county health department created pursuant to §16-2-1 *et seq*. of this code; any person designated as a 21st Century Learner Fellow pursuant to §18A-3-11 of this code; and any person who works as a long-term substitute as defined in §18A-1-1 of this code in the service of a county board of education: *Provided*, That a long-term substitute who is continuously employed for at least 133 instructional days during an instructional term, and, until the end of that instructional term, is eligible for the benefits provided in this article until September 1 following that instructional term: *Provided, however*, That a long-term substitute employed fewer than 133 instructional days during an instructional term is eligible for the benefits provided in this article only during such time as he or she is actually employed as a long-term substitute. On and after January 1, 1994, and upon election by a county board of education to allow elected board members to participate in the Public Employees Insurance Program pursuant to this article, any person elected to a county board of education shall be considered to be an "employee" during the term of office of the elected member. Upon election by the State Board of Education to allow appointed board members to participate in the Public Employees Insurance Program pursuant to this article, any person appointed to the State Board of Education is considered an "employee" during the term of office of the appointed member: *Provided further*, That the elected member of a county board of education and the appointed member of the State Board of Education shall pay the entire cost of the premium if he or she elects to be covered under this article. Any matters of doubt as to who is an employee within the meaning of this article shall be decided by the director.

On or after July 1, 1997, a person shall be considered an "employee" if that person meets the following criteria:

(A) Participates in a job-sharing arrangement as defined in §18A-1-1 *et seq*. of this code;

(B) Has been designated, in writing, by all other participants in that job-sharing arrangement as the "employee" for purposes of this section; and

(C) Works at least one-third of the time required for a full-time employee.

"Employer" means the State of West Virginia, its boards, agencies, commissions, departments, institutions, or spending units; a county board of education; a public charter school established pursuant to §18-5G-1 *et seq*. of this code if the charter school includes in its charter contract entered into pursuant to §18-5G-7 of this code a determination to participate in the Public Employees Insurance Program; a county, city, or town in the state; any separate corporation or instrumentality established by one or more counties, cities, or towns, as permitted by law; any corporation or instrumentality supported in most part by counties, cities, or towns; any public corporation charged by law with the performance of a

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governmental function and whose jurisdiction is coextensive with one or more counties, cities, or towns; any comprehensive community mental health center or intellectually and developmentally disabled facility established, operated, or licensed by the Secretary of the Department of Health and Human Resources pursuant to §27-2A-1 *et seq*. of this code and which is supported in part by state, county, or municipal funds; a combined city-county health department created pursuant to §16-2-1 *et seq*. of this code; and a corporation meeting the description set forth in §18B-12-3 of this code that is employing a 21st Century Learner Fellow pursuant to §18A-3-11 of this code but the corporation is not considered an employer with respect to any employee other than a 21st Century Learner Fellow. Any matters of doubt as to who is an "employer" within the meaning of this article shall be decided by the director. The term "employer" does not include within its meaning the National Guard.

"Established patient" means a patient who has received professional services, face-to-face, from the physician, qualified health care professional, or another physician or qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

"Finance board" means the Public Employees Insurance Agency finance board created by this article.

"Health care practitioner" means a person licensed under §30-1-1 *et seq*. of this code who provides health care services.

"Originating site" means the location where the patient is located, whether or not accompanied by a health care practitioner, at the time services are provided by a health care practitioner through telehealth, including, but not limited to, a health care practitioner's office, hospital, critical access hospital, rural health clinic, federally qualified health center, a patient’s home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

"Objective evidence" means standardized patient assessment instruments, outcome measurements tools, or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during, and after treatment is recommended to quantify progress and support justifications for continued treatment. The tools are not required but their use will enhance the justification for continued treatment.

"Person" means any individual, company, association, organization, corporation, or other legal entity.

"Plan" means a group hospital and surgical insurance plan or plans, a group prescription drug insurance plan or plans, a group major medical insurance plan or plans, and a group life and accidental death insurance plan or plans.

"Prescription insulin drug" means a prescription drug that contains insulin and is used to

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treat diabetes, and includes at least one type of insulin in all of the following categories:

(1) Rapid-acting;

(2) Short-acting;

(3) Intermediate-acting;

(4) Long-acting;

(5) Pre-mixed insulin products;

(6) Pre-mixed insulin/GLP-1 RA products; and

(7) Concentrated human regular insulin.

"Primary coverage" means individual or group hospital and surgical insurance coverage or individual or group major medical insurance coverage or group prescription drug coverage in which the spouse or dependent is the named insured or certificate holder.

"Remote patient monitoring services" means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

"Retired employee" means an employee of the state who retired after April 29, 1971, and an employee of the Higher Education Policy Commission, the Council for Community and Technical College Education, a state institution of higher education, or a county board of education who retires on or after April 21, 1972, and all additional eligible employees who retire on or after the effective date of this article, meet the minimum eligibility requirements for their respective state retirement system, and whose last employer immediately prior to retirement under the state retirement system is a participating employer in the state retirement system and in the Public Employees Insurance Agency: *Provided*, That for the purposes of this article, the employees who are not covered by a state retirement system, but who are covered by a state-approved or state-contracted retirement program or a system approved by the director, shall, in the case of education employees, meet the minimum eligibility requirements of the State Teachers Retirement System, and in all other cases, meet the minimum eligibility requirements of the Public Employees Retirement System and may participate in the Public Employees Insurance Agency as retired employees upon terms as the director sets by rule as authorized in this article. Employers with employees who are, or who are eligible to become, retired employees under this article shall be mandatory participants in the Retiree Health Benefit Trust Fund created pursuant to §5-16D-1 *et seq*. of this code. Nonstate employers may opt out of the West Virginia other post-employment benefits plan of the Retiree Health Benefit Trust Fund and elect to not provide benefits under the Public Employees Insurance Agency to retirees of the nonstate employer, but may

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do so only upon the written certification, under oath, of an authorized officer of the employer that the employer has no employees who are, or who are eligible to become, retired employees and that the employer will defend and hold harmless the Public Employees Insurance Agency from any claim by one of the employer's past, present, or future employees for eligibility to participate in the Public Employees Insurance Agency as a retired employee. As a matter of law, the Public Employees Insurance Agency shall not be liable in any respect to provide plan benefits to a retired employee of a nonstate employer which has opted out of the West Virginia other post-employment benefits plan of the Retiree Health Benefit Trust Fund pursuant to this section.

"Telehealth services" means the use of synchronous or asynchronous telecommunications technology or audio-only telephone calls by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include e-mail messages or facsimile transmissions.

"Virtual telehealth" means a new patient or follow-up patient for acute care that does not require chronic management or scheduled medications.

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§5-16-3. Composition of Public Employees Insurance Agency.

(a) The Public Employees Insurance Agency consists of the director, the finance board, the advisory board, and any employees who may be authorized by law. The director shall be appointed by the Governor, with the advice and consent of the Senate, and serve at the will and pleasure of the Governor. The director shall have at least three years' experience in health or governmental health benefit administration as his or her primary employment duty prior to appointment as director. The director shall receive actual expenses incurred in the performance of official business. The director shall employ any administrative, technical, and clerical employees required for the proper administration of the programs provided in this article. The director shall perform the duties that are required of him or her under the provisions of this article and is the Chief Administrative Officer of the Public Employees Insurance Agency. The director may employ a deputy director.

(b) Except for the director, his or her personal secretary, the deputy director, and the chief financial officer, all positions in the agency shall be included in the classified service of the civil service system pursuant to §29-6-1 *et seq*. of this code.

(c) The director is responsible for the administration and management of the Public Employees Insurance Agency as provided in this article and in connection with his or her responsibility may make all rules necessary to effectuate the provisions of this article. Nothing in §5-16-4 or §5-16-5 of this code limits the director's ability to manage on a day-to-day basis the group insurance plans required or authorized by this article, including, but not limited to, administrative contracting, studies, analyses and audits, eligibility determinations, utilization management provisions and incentives, provider negotiations, provider contracting and payment, designation of covered and noncovered services, offering of additional coverage options or cost containment incentives, pursuit of coordination of benefits, and subrogation, or any other actions which would serve to implement the plan or plans designed by the finance board. The director is to function as a benefits management professional and should avoid political involvement in managing the affairs of the Public Employees Insurance Agency.

(d) The director may, if it is financially advantageous to the state, operate the Medicare retiree health benefit plan offered by the agency based on a plan year that runs concurrent with the calendar year. Financial plans as addressed in section five of this article shall continue to be on a fiscal-year basis.

(e) The director should make every effort to evaluate and administer programs to improve quality, improve health status of members, develop innovative payment methodologies, manage health care delivery costs, evaluate effective benefit designs, evaluate cost sharing and benefit-based programs, and adopt effective industry programs that can manage the long-term effectiveness and costs for the programs at the Public Employees Insurance Agency to include, but not be limited to:

(1) Increasing generic fill rates;

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(2) Managing specialty pharmacy costs;

(3) Implementing and evaluating medical home models and health care delivery;

(4) Coordinating with providers, private insurance carriers, and, to the extent possible, Medicare to encourage the establishment of cost-effective accountable care organizations;

(5) Exploring and developing advanced payment methodologies for care delivery such as case rates, capitation, and other potential risk-sharing models and partial risk-sharing models for accountable care organizations and medical homes;

(6) Adopting measures identified by the Centers for Medicare and Medicaid Services to reduce cost and enhance quality;

(7) Evaluating the expenditures to reduce excessive use of emergency room visits, imaging services, and other drivers of the agency's medical rate of inflation;

(8) Recommending cutting-edge benefit designs to the finance board to drive behavior and control costs for the plans;

(9) Implementing programs to encourage the use of the most efficient and high-quality providers by employees and retired employees;

(10) Identifying employees and retired employees who have multiple chronic illnesses and initiating programs to coordinate the care of these patients;

(11) Initiating steps to adjust payment by the agency for the treatment of hospital-acquired infections and related events consistent with the payment policies, operational guidelines, and implementation timetable established by the Centers of Medicare and Medicaid Services. The agency shall protect employees and retired employees from any adjustment in payment for hospital acquired infections; and

(12) Initiating steps to reduce the number of employees and retired employees who experience avoidable readmissions to a hospital for the same diagnosis-related group illness within 30 days of being discharged by a hospital in this state or another state consistent with the payment policies, operational guidelines, and implementation timetable established by the Centers of Medicare and Medicaid Services.

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§5-16-4. Public Employees Insurance Agency Finance Board.

(a) The Public Employees Insurance Agency Finance Board is continued and consists of the Secretary of the Department of Administration or his or her designee, as a voting member, and 10 members appointed by the Governor, with the advice and consent of the Senate, for terms of four years and each may serve until his or her successor is appointed and qualified. Members may be reappointed for successive terms. No more than six members, including the Secretary of the Department of Administration, may be of the same political party. Members of the board shall satisfy the qualification requirements provided for by subsection (b) of this section. The Governor shall make appointments necessary to satisfy the requirements of subsection (b) of this section to staggered terms as determined by the Governor.

(b) (1) Of the 10 members appointed by the Governor with advice and consent of the Senate:

(A) One member shall represent the interests of education employees. The member shall hold a bachelor's degree, shall have obtained teacher certification, shall be employed as a teacher for a period of at least three years prior to his or her appointment, and shall remain a teacher for the duration of his or her appointment to remain eligible to serve on the board.

(B) One member shall represent the interests of public employees. The member shall be employed to perform full- or part-time service for wages, salary, or remuneration for a public body for a period of at least three years prior to his or her appointment and shall remain an employee of a public body for the duration of his or her appointment to remain eligible to serve on the board.

(C) One member shall represent the interests of retired employees. The member shall meet the definition of retired employee as provided in §5-16-2 of this code.

(D) One member shall represent the interests of a participating political subdivision. The member shall have been employed by a political subdivision for a period of at least three years prior to his or her appointment and shall remain an employee of a political subdivision for the duration of his or her appointment to remain eligible to serve on the board. The member may not be an elected official.

(E) One member shall represent the interests of hospitals. The member shall have been employed by a hospital for a period of at least three years prior to his or her appointment and shall remain an employee of a hospital for the duration of his or her appointment to remain eligible to serve on the board.

(F) One member shall represent the interests of non-hospital health care providers. The member shall have owned his or her non-hospital health care provider business for a period of at least three years prior to his or her appointment and shall maintain ownership of his or her non-hospital health care provider business for the duration of his or her appointment to remain eligible to serve on the board.

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(G) Four members shall be selected from the public at large, meeting the following requirements:

(i) One member selected from the public at large shall generally have knowledge and expertise relating to the financing, development, or management of employee benefit programs;

(ii) One member selected from the public at large shall have at least three years of experience in the insurance benefits business;

(iii) One member selected from the public at large shall be a certified public accountant with at least three years of experience with financial management and employee benefits program experience; and

(iv) One member selected from the public at large shall be a health care actuary or certified public accountant with at least three years of financial experience with the health care marketplace.

(2) No member of the board may be a registered lobbyist.

(3) All appointments shall be selected to represent the different geographical areas within the state and all members shall be residents of West Virginia. No member may be removed from office by the Governor except for official misconduct, incompetence, neglect of duty, neglect of fiduciary duty, or other specific responsibility imposed by this article or gross immorality.

(4) All members of the board shall have a fiduciary responsibility to protect plan assets for the benefit of plan participants.

(5) Beginning July 1, 2023, and every year thereafter, all board members shall complete fiduciary training and timely complete any conflict-of-interest forms required to serve as a fiduciary.

(c) The Secretary of the Department of Administration shall serve as chair of the finance board, which shall meet at times and places specified by the call of the chair or upon the written request to the chair by at least two members. The Director of the Public Employees Insurance Agency shall serve as staff to the board. Notice of each meeting shall be given in writing to each member by the director at least three days in advance of the meeting. Six members shall constitute a quorum. The board shall pay each member the same compensation and expense reimbursement that is paid to members of the Legislature for their interim duties for each day or portion of a day engaged in the discharge of official duties.

(d) Upon termination of the board and notwithstanding any provisions of this article to the contrary, the director is authorized to assess monthly employee premium contributions and to change the types and levels of costs to employees only in accordance with this subsection.

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Any assessments or changes in costs imposed pursuant to this subsection shall be implemented by legislative rule proposed by the director for promulgation pursuant to §29A-3-1 *et seq*. of this code. Any employee assessments or costs previously authorized by the finance board shall then remain in effect until amended by rule of the director promulgated pursuant to this subsection.

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§5-16-4a.

Repealed.

Acts, 2010 Reg. Sess., Ch. 32.

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§5-16-5. Powers and duties of the finance board.

(a) The purpose of the finance board is to bring fiscal stability to the Public Employees Insurance Agency through development of annual financial plans and long-range plans designed to meet the agency's estimated total financial requirements, taking into account all revenues projected to be made available to the agency and apportioning necessary costs equitably among participating employers, employees, and retired employees and providers of health care services.

(b) The finance board shall retain the services of an impartial, professional actuary, with demonstrated experience in analysis of large group health insurance plans, to estimate the total financial requirements of the Public Employees Insurance Agency for each fiscal year and to review and render written professional opinions as to financial plans proposed by the finance board. The actuary shall also assist in the development of alternative financing options and perform any other services requested by the finance board or the director. All reasonable fees and expenses for actuarial services shall be paid by the Public Employees Insurance Agency. Any financial plan or modifications to a financial plan approved or proposed by the finance board shall be submitted to and reviewed by the actuary and may not be finally approved and submitted to the Governor and to the Legislature without the actuary's written professional opinion that the plan may be reasonably expected to generate sufficient revenues to meet all estimated program and administrative costs of the agency, including incurred but unreported claims, for the fiscal year for which the plan is proposed.

(c) All financial plans shall establish:

(1) The minimum level of reimbursement at 110 percent of the Medicare amount for all providers: *Provided*, That the plan shall reimburse a West Virginia hospital that provides inpatient medical care to a beneficiary, covered by the state and non-state plans, at a minimum rate of 110 percent of the Medicare diagnosis-related group rate for the admission, or the Medicare per diem, per day rate applicable to a critical access hospital, as appropriate: *Provided, however*, That the rates established pursuant to this subdivision do not apply to any Medicare primary retiree health plan.

(2) Any necessary cost-containment measures for implementation by the director;

(3) The levels of premium costs to participating employers; and

(4) The types and levels of cost to participating employees and retired employees.

The financial plans may provide for different levels of costs based on the insureds' ability to pay. The finance board may establish different levels of costs to retired employees based upon length of employment with a participating employer, ability to pay, or other relevant factors. The financial plans may also include optional alternative benefit plans with alternative types and levels of cost. The finance board may develop policies which encourage the use of West Virginia health care providers.

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In addition, the finance board may allocate a portion of the premium costs charged to participating employers to subsidize the cost of coverage for participating retired employees, on such terms as the finance board determines are equitable and financially responsible.

(d)(1) The finance board shall prepare an annual financial plan for each fiscal year. The finance board chairman shall request the actuary to estimate the total financial requirements of the Public Employees Insurance Agency for the fiscal year.

(2) The finance board shall prepare a proposed financial plan designed to generate revenues sufficient to meet all estimated program and administrative costs of the Public Employees Insurance Agency for the fiscal year. The proposed financial plan shall allow for no more than 30 days of accounts payable to be carried over into the next fiscal year. Before final adoption of the proposed financial plan, the finance board shall request the actuary to review the plan and to render a written professional opinion stating whether the plan will generate sufficient revenues to meet all estimated program and administrative costs of the Public Employees Insurance Agency for the fiscal year. The actuary's report shall explain the basis of its opinion. If the actuary concludes that the proposed financial plan will not generate sufficient revenues to meet all anticipated costs, then the finance board shall make necessary modifications to the proposed plan to ensure that all actuarially determined financial requirements of the agency will be met.

(3) Upon obtaining the actuary's opinion, the finance board shall conduct at least two public hearings in each congressional district to receive public comment on the proposed financial plan, shall review the comments, and shall finalize and approve the financial plan.

(4) For each fiscal year, the Governor shall provide his or her estimate of total revenues to the finance board no later than October 15 of the preceding fiscal year: *Provided*, That for the prospective financial plans required by this section, the Governor shall estimate the revenues available for each fiscal year of the plans based on the estimated percentage of growth in general fund revenues: *Provided, however*, That the director and finance board may only use revenue estimates from the Governor as necessary to maintain an actuarially recommended reserve fund and to maintain premium cost-sharing percentages as required in this article: *Provided, further*, That the director and finance board may not incorporate revenue sources into the finance board plan beyond the premium cost-sharing percentages as required in this article. The director shall provide the number of covered lives for the current fiscal year and a five-year analysis of the costs for covering paid claims to the finance board no later than October 15 of the preceding year. The finance board shall submit its final approved financial plan after obtaining the necessary actuary's opinion, which opinion shall include, but not be limited to, the aggregate premium cost-sharing percentages between employers and employees, including the amounts of any subsidization of retired employee benefits, at a level of 80 percent for the employer and 20 percent for employees, to the Governor and to the Legislature no later than January 1 preceding the fiscal year. The financial plan for a fiscal year becomes effective and shall be implemented by the director on July 1 of the fiscal year. In addition to each final approved financial plan required under this section, the finance board shall also simultaneously submit financial statements based on

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generally accepted accounting practices (GAAP) and the final approved plan restated on an accrual basis of accounting, which shall include allowances for incurred but not reported claims. The financial statements and the accrual-based financial plan restatement shall not affect the approved financial plan.

(e) The provisions of §29A-1-1 et seq. of this code shall not apply to the preparation, approval and implementation of the financial plans required by this section.

(f) By January 1 of each year, the finance board shall submit to the Governor and the Legislature a prospective financial plan for a period not to exceed five years for the programs provided in this article. Factors the board shall consider include, but are not limited to, the trends for the program and the industry; the medical rate of inflation; utilization patterns; cost of services; and specific information such as average age of employee population, active to retiree ratios, the service delivery system, and health status of the population.

(g) The prospective financial plans shall be based on the estimated revenues submitted in accordance §5-16-5(d)(4) of this code and shall include an average of the projected cost-sharing percentages of premiums and an average of the projected deductibles and copays for the various programs. Each plan year, the aggregate premium cost-sharing percentages between employers and employees, including the amounts of any subsidization of retired employee benefits, shall be at a level of 80 percent for the employer and 20 percent for employees, except for the employers provided in §5-16-18(d) of this code whose premium cost-sharing percentages shall be governed by that subsection. After the submission of the initial prospective plan, the board may not increase costs to the participating employers or change the average of the premiums, deductibles, and copays for employees, except in the event of a true emergency. If the board invokes the emergency provisions, the cost shall be borne between the employers and employees in proportion to the cost-sharing ratio for that plan year. For purposes of this section, "emergency" means that the most recent projections demonstrate that plan expenses will exceed plan revenues by more than one percent in any plan year. The aggregate premium cost-sharing percentages between employers and employees, including the amounts of any subsidization of retired employee benefits, may be offset, in part, by a legislative appropriation for that purpose.

(h) The finance board shall meet on at least a quarterly basis to review implementation of its current financial plan in light of the actual experience of the Public Employees Insurance Agency. The board shall review actual costs incurred, any revised cost estimates provided by the actuary, expenditures, and any other factors affecting the fiscal stability of the plan, and may make any additional modifications to the plan necessary to ensure that the total financial requirements of the agency for the current fiscal year are met. The finance board may not increase the types and levels of cost to employees during its quarterly review except in the event of a true emergency.

(i) For any fiscal year in which legislative appropriations differ from the Governor’s estimate of general and special revenues available to the agency, the finance board shall, within 30

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days after passage of the budget bill, make any modifications to the plan necessary to ensure that the total financial requirements of the agency for the current fiscal year are met.

(j) In the event the revenues in a given year exceed the expenses, the amount of revenues in excess of the expenses shall be retained by the Public Employees Insurance Agency to offset future premium increases.

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§5-16-5a. Retiree premium subsidy from Retiree Health Benefit Trust for hires prior to July 1, 2010.

The Finance Board may include in its financial plans a subsidy from the Retiree Health Benefit Trust Fund created by article sixteen-d of this chapter for the cost of coverage under the major health care benefits plans, only for retired employees who were hired before July 1, 2010.

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§5-16-5b. Creation of trust for retirees hired on or after July 1, 2010.

[Repealed.]

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§5-16-6.

Repealed.

Acts, 2009 Reg. Sess., Ch. 22.

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§5-16-7. Authorization to establish plans; mandated benefits; optional plans; separate rating for claims experience purposes.

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

(1) Coverages and benefits for x-ray and laboratory services in connection with mammograms when medically appropriate and consistent with current guidelines from the United States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or the American College of Obstetricians and Gynecologists; and a test for the human papilloma virus when medically appropriate and consistent with current guidelines from either the United States Preventive Services Task Force or the American College of Obstetricians and Gynecologists, when performed for cancer screening or diagnostic services on a woman age 18 or over;

(2) Annual checkups for prostate cancer in men age 50 and over;

(3) Annual screening for kidney disease as determined to be medically necessary by a physician using any combination of blood pressure testing, urine albumin or urine protein testing, and serum creatinine testing as recommended by the National Kidney Foundation;

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

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

(6) Coverage for treatment of serious mental illness:

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

(i) Schizophrenia and other psychotic disorders;

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(ii) Bipolar disorders;

(iii) Depressive disorders;

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

(v) Anxiety disorders; and

(vi) Anorexia and bulimia.

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

(B) The agency shall not discriminate between medical-surgical benefits and mental health benefits in the administration of its plan. With regard to both medical-surgical and mental health benefits, it may make determinations of medical necessity and appropriateness and it may use recognized health care quality and cost management tools including, but not limited to, limitations on inpatient and outpatient benefits, utilization review, implementation of cost-containment measures, preauthorization for certain treatments, setting coverage levels, setting maximum number of visits within certain time periods, using capitated benefit arrangements, using fee-for-service arrangements, using third-party administrators, using provider networks, and using patient cost sharing in the form of copayments, deductibles, and coinsurance. Additionally, the agency shall comply with the financial requirements and quantitative treatment limitations specified in 45 CFR 146.136(c)(2) and (c)(3), or any successor regulation. The agency may not apply any nonquantitative treatment limitations to benefits for behavioral health, mental health, and substance use disorders that are not applied to medical and surgical benefits within the same classification of benefits: *Provided*, That any service, even if it is related to the behavioral health, mental health, or substance use diagnosis if medical in nature, shall be reviewed as a medical claim and undergo all utilization review as applicable;

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

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

(B) A child who is 12 years of age or younger with documented phobias or with documented mental illness and with dental needs of such magnitude that treatment should not be delayed

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or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth, or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

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

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

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

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

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

(iii) There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

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

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

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(10) (A) Coverage, through the age of 20, for amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state pursuant to either §30-3-1 *et seq*. or §30-14-1 *et seq*. of this code:

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

(ii) Severe food protein-induced enterocolitis syndrome;

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

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

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

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

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

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

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

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

(b) The agency shall make available to each eligible employee, at full cost to the employee,

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the opportunity to purchase optional group life and accidental death insurance as established under the rules of the agency. In addition, each employee is entitled to have his or her spouse and dependents, as defined by the rules of the agency, included in the optional coverage, at full cost to the employee, for each eligible dependent.

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

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

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

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

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

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

(e) The agency shall establish procedures to authorize treatment with a nonparticipating provider if a covered service is not available within established time and distance standards 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.

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

(g) 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 service continues to be a covered service until the Public Employees Insurance Agency notifies the covered person of the determination of the claim.

(h) 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 substance use disorders by the Public Employees Insurance Agency shall include the following language:

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

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

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

(i) On or after June 1, 2021, and annually thereafter, the Public Employees Insurance Agency shall submit a written report to the Joint Committee on Government and Finance that contains the following 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, mental health, and substance use disorders; and

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

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

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

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

(A) Identify factors used to determine whether a nonquantitative treatment limitation will

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

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

(C) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the written processes and strategies used to apply each nonquantitative treatment limitation for benefits for behavioral health, 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 each nonquantitative treatment limitation, as written, and the written processes and strategies used to apply each nonquantitative treatment limitation for medical and surgical benefits;

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

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

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

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

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§5-16-7a. Additional mandated benefits; third party reimbursement for colorectal cancer examination and laboratory testing.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, reimbursement or indemnification for colorectal cancer examinations and laboratory testing may not be denied for any nonsymptomatic person fifty years of age or older, or a symptomatic person under fifty years of age, when reimbursement or indemnity for laboratory or X ray services are covered under the policy and are performed for colorectal cancer screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery by the board of Medicine. The tests are as follows: An annual fecal occult blood test, a flexible sigmoidoscopy repeated every five years, a colonoscopy repeated every ten years and a double contrast barium enema repeated every five years.

(b) A symptomatic person is defined as: (1) An individual who experiences a change in bowel habits, rectal bleeding or stomach cramps that are persistent; or (2) an individual who poses a higher than average risk for colorectal cancer because he or she has had colorectal cancer or polyps, inflammatory bowel disease, or an immediate family history of such conditions.

(c) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered person may apply to colorectal cancer examinations and laboratory testing.

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§5-16-7b. Coverage for telehealth services.

(a) The plan shall provide coverage of health care services provided through telehealth services if those same services are covered through face-to-face consultation by the policy.

(b) The plan may not exclude a service for coverage solely because the service is provided through telehealth services.

(c) The plan shall provide reimbursement for a telehealth service at a rate negotiated between the provider and the insurance company for virtual telehealth encounters. The plan shall provide reimbursement for a telehealth service for an established patient, or care rendered on a consulting basis to a patient located in an acute care facility, whether inpatient or outpatient, on the same basis and at the same rate under a contract, plan, agreement, or policy as if the service is provided through an in-person encounter rather than provided via telehealth.

(d) The plan may not impose any annual or lifetime dollar maximum on coverage for telehealth services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to the provisions of or the requirements of this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

(e) An originating site may charge the plan a site fee.

(f) The coverage required by this section shall include the use of telehealth technologies as it pertains to medically necessary remote patient monitoring services to the full extent that those services are available.

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§5-16-7c. Required coverage for reconstruction surgery following mastectomies.

(a) The plan shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

(1) All stages of reconstruction of the breast on which the mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Prostheses and physical complications of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient. Coverage shall be provided for a minimum stay in the hospital of not less than 48 hours for a patient following a radical or modified mastectomy and not less than 24 hours of inpatient care following a total mastectomy or partial mastectomy with lymph node dissection for the treatment of breast cancer. Nothing in this section shall be construed as requiring inpatient coverage where inpatient coverage is not medically necessary or where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter in the summary plan description or similar document.

(b) The plan may not:

(1) Deny a patient eligibility, or continued eligibility, to enroll or renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

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§5-16-7d. Coverage for patient cost of clinical trials.

(a) The provisions of this section and section seven-e of this article apply to the health plans regulated by this article.

(b) This section does not apply to a policy, plan or contract paid for under Title XVIII of the Social Security Act.

(c) A policy, plan or contract subject to this section shall provide coverage for patient cost to a member in a clinical trial, as a result of:

(1) Treatment provided for a life-threatening condition; or

(2) Prevention of, early detection of or treatment studies on cancer.

(d) The coverage under subsection (c) of this section is required if:

(1)(A) The treatment is being provided or the studies are being conducted in a Phase II, Phase III or Phase IV clinical trial for cancer and has therapeutic intent; or

(B) The treatment is being provided in a Phase II, Phase III or Phase IV clinical trial for any other life-threatening condition and has therapeutic intent;

(2) The treatment is being provided in a clinical trial approved by:

(A) One of the national institutes of health;

(B) An NIH cooperative group or an NIH center;

(C) The FDA in the form of an investigational new drug application or investigational device exemption;

(D) The federal department of Veterans Affairs; or

(E) An institutional review board of an institution in the state which has a multiple project assurance contract approved by the office of protection from research risks of the national institutes of health;

(3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise;

(4) There is no clearly superior, noninvestigational treatment alternative;

(5) The available clinical or preclinical data provide a reasonable expectation that the treatment will be more effective than the noninvestigational treatment alternative;

(6) The treatment is provided in this state: Provided, That, if the treatment is provided

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outside of this state, the treatment must be approved by the payor designated in subsection (a) of this section;

(7) Reimbursement for treatment is subject to all coinsurance, copayment and deductibles and is otherwise subject to all restrictions and obligations of the health plan; and

(8) Reimbursement for treatment by an out of network or noncontracting provider shall be reimbursed at a rate which is no greater than that provided by an in network or contracting provider. Coverage shall not be required if the out of network or noncontracting provider will not accept this level of reimbursement.

(e) Payment for patient costs for a clinical trial is not required by the provisions of this section, if:

(1) The purpose of the clinical trial is designed to extend the patent of any existing drug, to gain approval or coverage of a metabolite of an existing drug, or to gain approval or coverage relating to additional clinical indications for an existing drug; or

(2) The purpose of the clinical trial is designed to keep a generic version of a drug from becoming available on the market; or

(3) The purpose of the clinical trial is to gain approval of or coverage for a reformulated or repackaged version of an existing drug.

(f) Any provider billing a third party payor for services or products provided to a patient in a clinical trial shall provide written notice to the payor that specifically identifies the services as part of a clinical trial.

(g) Notwithstanding any provision in this section to the contrary, coverage is not required for Phase I of any clinical trial.

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§5-16-7e. Definitions.

For purposes of section seven-d of this article:

(a) A "clinical trial" is a study that determines whether new drugs, treatments or medical procedures are safe and effective on humans. To determine the efficacy of experimental drugs, treatments or procedures, a study is conducted in four phases including the following:

Phase II: The experimental drug or treatment is given to, or a procedure is performed on, a larger group of people to further measure its effectiveness and safety.

Phase III: Further research is conducted to confirm the effectiveness of the drug, treatment or procedure, to monitor the side effects, to compare commonly used treatments and to collect information on safe use.

Phase IV: After the drug, treatment or medical procedure is marketed, investigators continue testing to determine the effects on various populations and to determine whether there are side effects associated with long-term use.

(b) "Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group.

(c) "Cooperative group" includes:

(1) The national cancer institute clinical cooperative group;

(2) The national cancer institute community clinical oncology program;

(3) The AIDS clinical trial group; and

(4) The community programs for clinical research in AIDS.

(d) "FDA" means the federal food and drug administration.

(e) "Life-threatening condition" means that the member has a terminal condition or illness that according to current diagnosis has a high probability of death within two years, even with treatment with an existing generally accepted treatment protocol.

(f) "Member" means a policyholder, subscriber, insured, certificate holder or a covered dependent of a policyholder, subscriber, insured or certificate holder.

(g) "Multiple project assurance contract" means a contract between an institution and the federal department of health and human services that defines the relationship of the institution to the federal department of health and human services and sets out the responsibilities of the institution and the procedures that will be used by the institution to

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protect human subjects.

(h) "NIH" means the national institutes of health.

(i) "Patient cost" means the routine costs of a medically necessary health care service that is incurred by a member as a result of the treatment being provided pursuant to the protocols of the clinical trial. Routine costs of a clinical trial include all items or services that are otherwise generally available to beneficiaries of the insurance policies. "Patient cost" does not include:

(1) The cost of the investigational drug or device;

(2) The cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided to the member for purposes of the clinical trial;

(3) Services customarily provided by the research sponsor free of charge for any participant in the trial;

(4) Costs associated with managing the research associated with the clinical trial including, but not limited to, services furnished to satisfy data collection and analysis needs that are not used in the direct clinical management of the participant; or

(5) Costs that would not be covered under the participant's policy, plan, or contract for noninvestigational treatments;

(6) Adverse events during treatment are divided into those that reflect the natural history of the disease, or its progression, and those that are unique in the experimental treatment. Costs for the former are the responsibility of the payor as provided in section two of this article, and costs for the later are the responsibility of the sponsor. The sponsor shall hold harmless any payor for any losses and injuries sustained by any member as a result of his or her participation in the clinical trial.

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§5-16-7f. Prior authorization.

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

"Episode of care" means a specific medical problem, condition, or specific illness being managed, including tests, procedures, and rehabilitation initially requested by the health care practitioner, to be performed at the site of service, excluding out-of-network care: *Provided*, That any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

"National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the United States Department of Health and Human Services;

"Prior authorization" means obtaining advance approval from the Public Employees Insurance Agency regarding the coverage of a service or medication.

(b) The Public Employees Insurance Agency shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the Public Employees Insurance Agency's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

(1) Include instructions for the submission of clinical documentation;

(2) Provide an electronic notification to the health care provider confirming receipt of the prior authorization request for forms submitted electronically;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the Public Employees Insurance Agency requires a prior authorization. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list shall be updated at least quarterly to ensure that the list remains current;

(4) Inform the patient if the Public Employees Insurance Agency requires a plan member to use step therapy protocols. This shall be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the Public Employees Insurance Agency and the step therapy has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by July 1, 2024.

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(c) The Public Employees Insurance Agency shall provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider.

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the Public Employees Insurance Agency shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request: *Provided*, That the Public Employees Insurance Agency shall respond to the prior authorization request within two business days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or

(2) In the opinion of a health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the Public Employees Insurance Agency shall identify all deficiencies, and within two business days from the day on the electronic receipt of the prior authorization, request return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the day the return request is received by the health care practitioner. The Public Employees Insurance Agency shall render a decision within two business day after receipt of the additional information submitted by the health care provider. If the health care practitioner fails to submit additional information, the prior authorization is considered denied and a new request shall be submitted.

(f) If the Public Employees Insurance Agency wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by the Public Employees Insurance Agency is carried over to all other managed care organizations and health insurers for three months if the services are provided within the state.

(h) The Public Employees Insurance Agency shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the Public Employees Insurance Agency and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner,

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similar in specialty, education, and background. The Public Employees Insurance Agency's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business days from the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization may not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the health care practitioner shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization shall be obtained.

(2) If the approval of a prior authorization requires a medication substitution, the substituted medication shall be as required under §30-5-1 *et seq*. of this code.

(k) If a health care practitioner has performed an average of 30 procedures per year and in a six-month time period during that year has received a 90 percent final prior approval rating, the Public Employees Insurance Agency shall not require the health care practitioner to submit a prior authorization for at least the next six months, or longer if the Public Employees Insurance Agency allows: *Provided*, That at the end of the six-month time frame, or longer if the Public Employees Insurance Agency allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time period equal to the previously granted time period, or longer if the Public Employees Insurance Agency allows. This exemption is subject to internal auditing, at any time, by the Public Employees Insurance Agency and may be rescinded if the Public Employees Insurance Agency determines the health care practitioner is not performing services or procedures in conformity with the Public Employees Insurance Agency's benefit plan, it identifies substantial variances in historical utilization, or identifies other anomalies based upon the results of the Public Employees Insurance Agency's internal audit. The Public Employees Insurance Agency shall provide a health care practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit the Public Employees Insurance Agency from requiring a prior authorization for an experimental treatment, non-covered benefit, pharmaceutical medication, or any out-of-network service or procedure.

(l) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to,

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prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, and the name of each physician whose gold card status was revoked and the reason for revocation.

(n) The Insurance Commissioner may assess a civil penalty for a violation of this section.

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§5-16-7g. Coverage for prescription insulin drugs.

(a) A policy, plan, or contract that is issued or renewed on or after January 1, 2024, shall provide coverage for prescription insulin drugs and equipment to this section.

(b) Cost sharing for a 30-day supply of a covered prescription insulin drug may not exceed $35 in aggregate, including situations where the covered person is prescribed more than one insulin drug, per 30-day supply, regardless of the amount or type of insulin needed to fill such covered person's prescription. Cost sharing for a 30-day supply of covered device(s) may not exceed $100 in aggregate, including situations where the covered person is prescribed more than one device, per 30-day supply. Each cost-share maximum is covered regardless of the person's deductible, copayment, coinsurance, or any other cost-sharing requirement.

(c) Nothing in this section prevents the agency from reducing a covered person's cost sharing by an amount greater than the amount specified in this subsection.

(d) No contract between the agency or its pharmacy benefits manager and a pharmacy or its contracting agent shall contain a provision: (i) Authorizing the agency's pharmacy benefits manager or the pharmacy to charge; (ii) requiring the pharmacy to collect; or (iii) requiring a covered person to make a cost-sharing payment for a covered prescription insulin drug in an amount that exceeds the amount of the cost-sharing payment for the covered prescription insulin drug established by the agency as provided in subsection (b) of this section.

(e) The agency shall provide coverage for the following equipment and supplies for the treatment or management of diabetes for both insulin-dependent and noninsulin-dependent persons with diabetes and those with gestational diabetes: Blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar, and orthotics.

(f) The agency shall provide coverage for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. Coverage for self-management education and education relating to diet shall be provided by a health care practitioner who has been appropriately trained as provided in §33-53-1(k) of this code.

(g) The education may be provided by a health care practitioner as part of an office visit for diabetes diagnosis or treatment, or by a licensed pharmacist for instructing and monitoring a patient regarding the proper use of covered equipment, supplies, and medications, or by a certified diabetes educator or registered dietitian.

(h) A pharmacy benefits manager, a health plan, or any other third party that reimburses a pharmacy for drugs or services shall not reimburse a pharmacy at a lower rate and shall not assess any fee, charge-back, or adjustment upon a pharmacy on the basis that a covered person's costs sharing is being impacted.

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§5-16-7h. Patient-centered treatment flexibility.

(a) For purposes of this section:

"Covered treatment" means a service, procedure, therapy, medication, or course of care covered under an agency health plan.

"Alternative treatment" means a different covered treatment for the same diagnosed condition or illness that is medically appropriate and clinically indicated,

"Prior authorization" means approval issued by the agency or its administrator authorizing coverage of a specific treatment.

(b) If a patient has received prior authorization from the agency for a covered treatment for a diagnosed condition, the patient may receive an alternative covered treatment for the same condition without requiring a new or additional prior authorization, subject to the requirements of

this section. A patient is not eligible to receive the alternative treatment and the original covered treatment at the same time.

(c) The agency shall provide coverage for an alternative treatment selected pursuant to subsection (b) of this section and may not deny coverage solely on the basis that the alternative treatment was not separately prior authorized, if:

(1) The alternative treatment is medically appropriate for the same diagnosed condition; and

(2) The total allowed cost to the agency for the alternative treatment does not exceed the allowed cost of the originally authorized treatment.

(d) Coverage under this section is subject to the following conditions:

(1) A licensed health care provider shall document in the patient's medical record that the alternative treatment is medically appropriate and intended to treat the same diagnosed condition as the originally authorized treatment.

(2) The agency may require reasonable documentation to verify that the allowed cost of the alternative treatment does not exceed the allowed cost of the originally authorized treatment, using established agency pricing methodologies.

(3) Nothing in this section requires coverage of a treatment that is not otherwise a covered benefit under the applicable agency health plan.

(4) The alternative treatment may not be used to initiate treatment for a new or unrelated diagnosis for which prior authorization would otherwise be required.

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(5) Nothing in this section limits the authority of the agency to conduct audits or deny claims in cases of fraud, waste, abuse, or material misrepresentation.

(e) The agency may not:

(1) Require a new prior authorization solely because a patient elects to receive an alternative covered treatment that meets the requirements of this section; or

(2) Impose administrative requirements that have the effect of unreasonably delaying access to an alternative treatment authorized under this section.

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§5-16-8. Conditions of insurance program.

The insurance plans provided for in this article shall be designed by the Public Employees Insurance Agency:

(1) To provide a reasonable relationship between the hospital, surgical, medical, and prescription drug benefits to be included and the expected reasonable and customary hospital, surgical, medical, and prescription drug expenses as established by the director to be incurred by the affected employee, his or her spouse, and his or her dependents. The establishment of reasonable and customary expenses by the Public Employees Insurance Agency pursuant to the preceding sentence is not subject to chapter §29A-1-1 *et seq*. of this code;

(2) To include reasonable controls which may include deductible and coinsurance provisions applicable to some or all of the benefits, and shall include other provisions, including, but not limited to, copayments, preadmission certification, case management programs, and preferred provider arrangements;

(3) To prevent unnecessary utilization of the various hospital, surgical, medical, and prescription drug services available;

(4) To provide reasonable assurance of stability in future years for the plans;

(5) To provide major medical insurance for the employees covered under this article;

(6) To provide certain group life and accidental death insurance for the employees covered under this article;

(7) To include provisions for the coordination of benefits payable by the terms of the plans with the benefits to which the employee, or his or her spouse, or his or her dependents may be entitled by the provisions of any other group hospital, surgical, medical, major medical, or prescription drug insurance, or any combination thereof;

(8) To provide a cash incentive plan for employees, spouses, and dependents to increase utilization of, and to encourage the use of, lower cost alternative health care facilities, health care providers, and generic drugs. The plan shall be reviewed annually by the director and the advisory board;

(9) To provide health and wellness programs and resources impacting various components of health and wellness. PEIA may explore, review, evaluate, and offer a variety of health and wellness programming and resources to meet the needs of its members. These programs are voluntary for participants and are separate and distinct from any medical benefit;

(10) To provide a program, to be administered by the director, for a patient audit plan with reimbursement up to a maximum of $1,000 annually to employees for discovery of health care provider or hospital overcharges when the affected employee brings the overcharge to

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the attention of the plan. The hospital or health care provider shall certify to the director that it has provided, prior to or simultaneously with the submission of the statement of charges for payments, an itemized statement of the charges to the employee participant for which payment is requested of the plan;

(11) To require that all employers give written notice to each covered employee prior to institution of any changes in benefits to employees, and to include appropriate penalty for any employer not providing the required information to any employee; and

(12) (A) To provide coverage for emergency services under offered plans.

(B) Plans shall provide coverage for emergency services, including any pre-hospital services, to the extent necessary to screen and stabilize the covered person. The plans shall reimburse, less any applicable copayments, deductibles, or coinsurance for emergency services rendered and related to the condition for which the covered person presented. Prior authorization of coverage shall not be required for the screening services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Prior authorization of coverage shall not be required for stabilization if an emergency medical condition exists. In the event that prior authorization was obtained, the authorization may not be retracted after the services have been provided except when the authorization was based on a material misrepresentation about the medical condition by the provider of the services or the insured person. The provider of the emergency services and the plan representative shall make a good faith effort to communicate with each other in a timely fashion to expedite post-evaluation or post-stabilization services. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(C) For purposes of this subdivision:

"Emergency services" means those services required to screen for or treat an emergency medical condition until the condition is stabilized, including pre-hospital care;

"Prudent layperson" means a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether an emergency medical condition exists for which emergency treatment should be sought;

"Emergency medical condition for the prudent layperson" means one that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the person could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual’s health, or, with respect to a pregnant woman, the health of the unborn child, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;

"Stabilize" means with respect to an emergency medical condition, to provide medical treatment of the condition necessary to assure, with reasonable medical probability that no

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medical deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility: *Provided*, That this provision may not be construed to prohibit, limit, or otherwise delay the transportation required for a higher level of care than that possible at the treating facility;

"Medical screening examination" means an appropriate examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists; and

"Emergency medical condition" means a condition that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health, or, with respect to a pregnant woman, the health of the unborn child, serious impairment to bodily functions, or serious dysfunction of any bodily part or organ.

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§5-16-8a. Air-ambulance fees.

(a) The plan shall reimburse any air-ambulance provider that provides emergency air transportation or related emergency medical or treatment services to an employee or dependent of an employee covered by the plan the amount then in effect for the federal Medicare program, including any applicable Geographic Practice Cost Index.

(b) Nothing in this section limits the authority of the director under §5-16-3(c) and §5-16-9 of this code, including, but not limited to, his or her authority to manage provider contracting and payments and to designate covered and noncovered services.

(c) This section does not limit the authority of the director, the plan, or the plans under §5-16-11 of this code.

(d) Notwithstanding any provision of this code to the contrary, wherever 49 U.S.C. §41713(b) applies to the reimbursement of air ambulance providers under §5-16-8a of this code, the provisions of this code, including any administrative, civil, or criminal penalties, are inapplicable.

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§5-16-8b. Required coverage for scalp cooling system for cancer chemotherapy treatment.

(a) For the purpose of this section, "scalp cooling system" means any device used to cool the human scalp to prevent or reduce hair loss during cancer chemotherapy treatment, provided that such device is designed and intended for repeated use and is primarily and customarily used to serve a medical purpose.

(b) Any insurer who delivers or issues a policy, plan, or contact that is issued or renewed on or after January 1, 2027, under the provisions of this article and provides coverage for cancer chemotherapy treatment shall provide coverage for scalp cooling systems used in connection with cancer chemotherapy treatment as defined by the Centers for Medicare and Medicaid Services. Coverage provided under this section may be subject to annual deductibles and coinsurance, including copayments, as may be deemed appropriate by the commissioner and as are consistent with those established for other benefits within a given policy.

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§5-16-9. Authorization to execute contracts.

(a) The director is given exclusive authorization to execute such contract or contracts as are necessary to carry out the provisions of this article.

(b) The provisions of §5A-3-1 *et seq*. of this code, relating to the Division of Purchasing of the Department of Finance and Administration, shall not apply to any contracts for any insurance coverage or professional services authorized to be executed under the provisions of this article. Before entering into any contract for any insurance coverage, as authorized in this article, the director shall invite competent bids from all qualified and licensed insurance companies or carriers that may wish to offer plans for the insurance coverage desired. The director shall negotiate and contract directly with health care providers and other entities, organizations, and vendors in order to secure competitive premiums, prices, and other financial advantages. The director shall deal directly with insurers or health care providers and other entities, organizations, and vendors in presenting specifications and receiving quotations for bid purposes. No commission or finder's fee, or any combination thereof, shall be paid to any individual or agent: *Provided*, That this shall not preclude an underwriting insurance company or companies, at their own expense, from appointing a licensed resident agent within this state to service the companies' contracts awarded under the provisions of this article. Commissions reasonably related to actual service rendered for the agent or agents may be paid by the underwriting company or companies. In no event shall payment be made to any agent or agents when no actual services are rendered or performed. The director shall award the contract or contracts on a competitive basis. In awarding the contract or contracts, the director shall consider the experience of the offering agency, corporation, insurance company, or service organization in the group hospital and surgical insurance field, group major medical insurance field, group prescription drug field, and group life and accidental death insurance field, and its facilities for the handling of claims. In evaluating these factors, the director may employ the services of impartial, professional insurance analysts or actuaries, or both. Any contract executed by the director with a selected carrier shall be a contract to govern all eligible employees subject to the provisions of this article. Nothing contained in this article shall prohibit any insurance carrier from soliciting employees covered hereunder to purchase additional hospital and surgical, major medical, or life and accidental death insurance coverage.

(c) The director may authorize the carrier with whom a primary contract is executed to reinsure portions of the contract with other carriers which elect to be a reinsurer and who are legally qualified to enter into a reinsurance agreement under the laws of this state.

(d) Each employee who is covered under any contract or contracts shall receive a statement of benefits to which the employee, his or her spouse, and his or her dependents are entitled under the contract, setting forth the information as to whom the benefits are payable, to whom claims shall be submitted, and a summary of the provisions of the contract or contracts as they affect the employee, his or her spouse, and his or her dependents.

(e) The director may at the end of any contract period discontinue any contract or contracts

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it has executed with any carrier and replace the same with a contract or contracts with any other carrier or carriers meeting the requirements of this article.

(f) The director shall include language in all contracts for pharmacy benefits management, as defined by §33-51-3 of this code, requiring the pharmacy benefit manager to report quarterly to the agency the following:

(1) The overall total amount charged to the agency for all claims processed by the pharmacy benefit manager during the quarter;

(2) The overall total amount of reimbursements paid to pharmacy providers during the quarter;

(3) The overall total number of claims in which the pharmacy benefits manager reimbursed a pharmacy provider for less than the amount charged to the agency for all claims processed by the pharmacy benefit manager during the quarter; and

(4) For all pharmacy claims, the total amount paid to the pharmacy provider per claim, including, but not limited to, the following:

(A) The cost of drug reimbursement;

(B) Dispensing fees;

(C) Copayments;

(D) The amount charged to the agency for each claim by the pharmacy benefit manager;

(E) Date of service;

(F) NDC-11;

(G) Drug name;

(H) Drug strength;

(I) Quantity;

(J) Days of therapy;

(K) Rx count;

(L) Mail/retail code;

(M) Brand/generic indicator;

(N) Specialty drug indicator;

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(O) Compound indicator;

(P) Formulary indicator;

(Q) Gross cost;

(R) Member cost;

(S) Plan cost;

(T) Dispense as written;

(U) Pharmacy NPI number;

(V) Pharmacy Claim ID;

(W) Prescriber NPI number;

(X) Pharmacy name; and

(Y) Ingredient cost.

In the event there is a difference between the amount for any pharmacy claim paid to the pharmacy provider and the amount reimbursed to the agency, the pharmacy benefit manager shall report an itemization of all administrative fees, rebates, or processing charges associated with the claim. The director shall provide an annual report to the Joint Committee on Health detailing the information required by this section, including any difference or spread between the overall amount paid by pharmacy benefit managers to the pharmacy providers and the overall amount charged to the agency for each claim by the pharmacy benefit manager. To the extent necessary, the director shall use aggregated, nonproprietary data only: *Provided*, That the director must provide a clear and concise summary of the total amounts charged to the agency and reimbursed to pharmacy providers on an annual basis.

(g) If the information required herein is not provided, the agency may terminate the contract with the pharmacy benefit manager and the Office of the Insurance Commissioner shall discipline the pharmacy benefit manager as provided in §33-51-8(e) of this code.

(h) The Public Employees Insurance Agency shall contract with networks to provide care to its members out of state.

(i) The Public Employees Insurance Agency shall require each of the following in its requests for proposals and contracts with a pharmacy benefit manager:

(1) The pharmacy benefit manager shall disclose all information and data related to contracting, reimbursement, networks, rebates, fees, and any other information and data requested by the Public Employees Insurance Agency, the Legislature, and vendors for the

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purpose of performing study and analysis.

(2) A pharmacy benefit manager shall not reimburse a West Virginia pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the national average drug acquisition cost for a prescription drug or pharmacy service at the time the drug is administered or dispensed, plus a professional dispensing fee at least equal to the professional dispensing fee paid by West Virginia Medicaid for outpatient drugs. Increases to the professional dispensing fee may be set by the director in accordance with this subdivision: *Provided*, That if the national average drug acquisition cost is not available at the time a drug is administered or dispensed, a pharmacy benefit manager may not reimburse a West Virginia pharmacy or pharmacist in an amount that is less than the wholesale acquisition cost of the drug, as defined in 42 U.S.C. § 1395w-3a(c)(6)(B), plus a dispensing fee as described in this subdivision. A West Virginia pharmacy is a domestic business entity as registered with the West Virginia Secretary of State. The provisions in this subdivision shall be effective for the Public Employees Insurance Agency plan year beginning on July 1, 2024.

(j) Any contract with the Public Employees Insurance Agency for pharmacy benefits management services with a pharmacy benefit manager is subject to the requirements of §33-51-1 *et seq*. of this code and the jurisdiction of the Office of the Insurance Commissioner: *Provided*, That the Public Employees Insurance Agency is not subject to §33-51-9(e) of this code, and nothing in this subsection shall be applied to conflict with Medicare.

(k) By July 1, 2026, the Public Employees Insurance Agency shall issue a competitive bid solicitation for a contract with a pharmacy cost containment vendor actively engaging prescribing providers by presenting information regarding cost and effectiveness, including but not limited to data related to lowest net cost pharmaceutical decisions and related to reductions to polypharmacy rates, if clinically reviewed and appropriate.

(1) The vendor managing this service shall be separate and distinct from any pharmacy benefit management contract that any state agency may have in the management of the pharmacy benefit.

(2) The vendor shall work with the Public Employees Insurance Agency to ensure that the lowest net cost outcome is achieved, including calculation of drug manufacturer rebates and other considerations that may be offered to the state, while not negatively impacting patient outcomes.

(3) Prescribing providers engaged by the vendor are not required to modify their prescribing based on the information presented pursuant to this subsection but the agency retains discretion to modify its drug formulary based on the vendor's recommendations.

(4) The pharmacy cost containment vendor contract shall contain provisions guaranteeing the state an itemized monthly activity and savings report and a total net savings guarantee

related to all expenditures and fees for the pharmacy cost containment service.

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§5-16-10. Contract provisions for group hospital and surgical, group major medical, group prescription drug and group life, and accidental death insurance for retired employees, their spouses, and dependents.

A plan may provide benefits for retired employees and their spouses and dependents as defined by rules and regulations of the Public Employees Insurance Agency, and on such terms as the director may deem appropriate.

In the event the Public Employees Insurance Agency provides the above benefits for retired employees, their spouses, and dependents, the Public Employees Insurance Agency shall adopt rules and regulations prescribing the conditions under which retired employees may elect to participate in or withdraw from the plan or plans. Any plan provided for shall be secondary to any insurance plan administered by the United States Department of Health and Human Services to which the retired employee, spouse, or dependent may be eligible under any law or regulation of the United States. If an employee eligible to participate in the Public Employees Insurance Agency plans is also eligible to participate in the state Medicaid program, and chooses to do so, then the Public Employees Insurance Agency may transfer to the Medicaid program funds to pay the required state share of such employee's participation in Medicaid except that the amount transferred may not exceed the amount that would be allocated by the agency to subsidize the cost of coverage for the retired employee if he or she were enrolled in the Public Employees Insurance Agency's plans.

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§5-16-11. To whom benefits paid.

Any benefits payable under a plan may be paid either directly to the medical provider, hospital, medical group, or other person, firm, association, or corporation furnishing the service upon which the claim is based, or to the insured upon presentation of valid bills for such service, subject to such provisions designed to facilitate payments as may be made by the director.

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§5-16-12. Misrepresentation by employer, employee or provider; penalty.

(a) It shall be a violation of this article for any person to:

(1) Knowingly secure or attempt to secure benefits payable under this article to which they are not entitled;

(2) Knowingly secure or attempt to secure greater benefits than those to which the person is entitled;

(3) Willfully misrepresent the presence or extent of benefits to which the person is entitled under a collateral insurance source;

(4) Willfully misrepresent any material fact relating to any other information requested by the director;

(5) Willfully overcharge for services provided; or

(6) Willfully misrepresent a diagnosis or nature of the service provided.

Any person who has violated any of the foregoing provisions shall be civilly liable for the amount of benefits, overpayment or other sums improperly received in addition to any other relief available in a court of competent jurisdiction.

(b) If, after notice and an administrative proceeding, it is determined the person has violated the article, the person is liable for any overpayment received. The director shall withhold and set off any payment of any benefits or other payment due to that person until any overpayment is recovered.

(c) In addition to any civil liability for a violation pursuant to subsection (a) of this section, any person who knowingly secures or attempts to secure benefits payable under this article, or knowingly attempts to secure greater benefits than those to which the person is entitled, by willfully misrepresenting or aiding in the misrepresentation of any material fact relating to employment, diagnosis or services rendered is guilty of a felony, and upon conviction thereof, shall be fined not more than $1,000, imprisoned for not less than one nor more than five years, or both. Errors in coding for billing purposes shall not be considered a violation of this subsection absent other evidence of willful wrongdoing.

(d) Any person who violates any provision of this article which results in a loss to, or overpayment from, the plan, or to the State of West Virginia of less than $1,000, and for which no other penalty is specifically provided, is guilty of a misdemeanor and, upon conviction thereof, is subject to a fine of not less than $100 but not more than $500, or imprisonment for a period of not less than twenty-four hours but not more than fifteen days, or both. Any person who violates any provision of this article which results in a loss to, or overpayment from, the plan or the State of West Virginia of $1,000 or more, and for which no other penalty is specifically provided, is guilty of a felony and, upon conviction thereof, is

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subject to a fine of not less than $1,000 but not more than $5,000, or imprisonment for a period of not less than one nor more than five years, or both.

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§5-16-12a. Inspections; violations and penalties.

(a) Employers and employees participating in any of the Public Employees Insurance Agency plans shall provide, to the director, upon request, all documentation reasonably required for the director to discharge the responsibilities under this article. This documentation includes, but is not limited to, employment or eligibility records sufficient to verify actual full-time employment and eligibility of employees who participate in the Public Employees Insurance Agency plans.

(b) Upon a determination of the director or his or her designated representative that there is probable cause to believe that fraud, abuse or other illegal activities involving transactions with the agency has occurred, the director or his or her designated representative is authorized to refer the alleged violations to the Insurance Commissioner for investigation and, if appropriate, prosecution, pursuant to article forty-one, chapter thirty-three of this code. For purposes of this section, "transactions with the agency" includes, but is not limited to, application by any insured or dependent, any employer or any type of health care provider for payment to be made to that person or any third party by the agency.

(c) The Public Employees Insurance Agency is authorized through administrative proceeding to recover any benefits or claims paid to or for any employee, or their dependents, who obtained or received benefits through fraud. The Public Employees Insurance Agency is also authorized through administrative proceeding to recover any funds due from an employer that knowingly allowed or provided benefits or claims to be fraudulently paid to an employee or dependents.

(d) For the purpose of any investigation or proceeding under this article, the director or any officer designated by him or her may administer oaths and affirmations, issue administrative subpoenas, take evidence, and require the production of any books, papers, correspondences, memoranda, agreements or other documents or records which may be relevant or material to the inquiry.

(1) Administrative subpoenas shall be served by personal service by a person over the age of eighteen, or by registered or certified mail addressed to the entity or person to be served at his or her residence, principal office or place of business. Proof of service, when necessary, shall be made by a return completed by the person making service, or in the case of registered or certified mail, such return shall be accompanied by the post office receipt of delivery of the subpoena. A party requesting the administrative subpoena is responsible for service and payment of any fees for service. Any person who serves the administrative subpoena pursuant to this section is entitled to the same fee as sheriffs who serve witness subpoenas for the circuit courts of this state.

(2) Fees for the attendance and travel of witnesses subpoenaed shall be the same as for witnesses before the circuit courts of this state. All such fees related to any administrative subpoena issued at the request of a party to an administrative proceeding shall be paid by the requesting party. All requests by parties for administrative subpoenas shall be in writing

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and shall contain a statement acknowledging that the requesting party agrees to pay such fees.

(3) In case of disobedience or neglect of any administrative subpoena served, or the refusal of any witness to testify to any matter for which he or she may be lawfully interrogated, or to produce documents subpoenaed, the circuit court of the county in which the hearing is being held, or the judge thereof in vacation, upon application by the director, may compel obedience by attachment proceedings for contempt as in the case of disobedience of the requirements of a subpoena or subpoena duces tecum issued from such circuit court or a refusal to testify therein. Witnesses at such hearings shall testify under oath or affirmation.

(e) Only authorized employees or agents shall have access to confidential data or systems and applications containing confidential data within the Public Employees Insurance Agency.

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§5-16-12b. Privileges and immunity.

(a) Any person who makes a report or furnishes information, written or oral, concerning suspected, anticipated or fraudulent activity to secure benefits payable under this article, or to secure greater benefits than those to which the person or provider is entitled, is entitled to those privileges and immunities existing under common or statutory law, as well as the immunity established in this section.

(b) In the absence of fraud, malice or bad faith, no person or agent, employee or designee of that person shall be subject to civil liability of any nature arising out of that person's provision of information related to suspected, anticipated or fraudulent activity in the securing of benefits payable or securing greater benefits than those to which the person or provider is entitled.

(c) Nothing in this section shall be construed to limit, abrogate or modify existing statutes or case law applicable to the duties or liabilities of persons acting in a manner that is itself fraudulent, with malice or in bad faith.

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§5-16-13. Payment of costs by employer and employee; spouse and dependent coverage; involuntary employee termination coverage; conversion of annual leave and sick leave authorized for health or retirement benefits; authorization for retiree participation; continuation of health insurance for surviving dependents of deceased employees; requirement of new health plan; limiting employer contribution.

(a) Cost-sharing. — The director shall provide plans that shall be paid by the employer and employee.

(b) Spouse and dependent coverage. —(1) An employee is entitled to have his or her spouse and dependents included in any plan to which the employee is entitled to participate.

(2) The spouse and dependent coverage is limited to excess or secondary coverage for each spouse and dependent who has primary coverage from any other source. If an employee's spouse has health insurance available through an employer not defined in §5-16-2 of this code, then the employer may not cover any portion of premiums for the employee's spouse coverage, unless the employee adds his or her spouse to his or her coverage by paying the cost of the actuarial value of the plan: *Provided*, That this does not apply to spouses of retired employees or employers subject to §5-16-22 of this code. For purposes of this subsection, "actuarial value" means the value as recommended by healthcare actuaries under §5-16-5 of this code.

The director may require proof regarding spouse and dependent primary coverage and shall adopt rules governing the nature, discontinuance, and resumption of any employee's coverage for his or her spouse and dependents.

(c) Continuation after termination. — If an employee participating in the plan is terminated from employment involuntarily or in reduction of work force, the employee's insurance coverage provided under this article shall continue for a period of three months at no additional cost to the employee and the employer shall continue to contribute the employer's share of plan premiums for the coverage. An employee discharged for misconduct shall not be eligible for extended benefits under this section. Coverage may be extended up to the maximum period of three months, while administrative remedies contesting the charge of misconduct are pursued. If the discharge for misconduct be upheld, the full cost of the extended coverage shall be reimbursed by the employee. If the employee is again employed or recalled to active employment within 12 months of his or her prior termination, he or she shall not be considered a new enrollee and may not be required to again contribute his or her share of the premium cost if he or she had already fully contributed such share during the prior period of employment.

(d) Conversion of accrued annual and sick leave for extended insurance coverage upon retirement for employees who elected to participate in the plan before July, 1988. — Except as otherwise provided in subsection (g) of this section, when an employee participating in the plan, who elected to participate in the plan before July 1, 1988, is compelled or required

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by law to retire before reaching the age of 65, or when a participating employee voluntarily retires as provided by law, that employee's accrued annual leave and sick leave, if any, shall be credited toward an extension of the insurance coverage provided by this article, according to the following formulae: The insurance coverage for a retired employee shall continue one additional month for every two days of annual leave or sick leave, or both, which the employee had accrued as of the effective date of his or her retirement. For a retired employee, his or her spouse and dependents, the insurance coverage shall continue one additional month for every three days of annual leave or sick leave, or both, which the employee had accrued as of the effective date of his or her retirement.(e) Conversion of accrued annual and sick leave for extended insurance coverage upon retirement for employees who elected to participate in the plan after June, 1988. — Notwithstanding subsection (d) of this section, and except as otherwise provided in subsections (g) and (l) of this section, when an employee participating in the plan who elected to participate in the plan on and after July 1, 1988, is compelled or required by law to retire before reaching the age of 65, or when the participating employee voluntarily retires as provided by law, that employee's annual leave or sick leave, if any, shall be credited toward one half of the premium cost of the insurance provided by this article, for periods and scope of coverage determined according to the following formulae: (1) One additional month of single retiree coverage for every two days of annual leave or sick leave, or both, which the employee had accrued as of the effective date of his or her retirement; or (2) one additional month of coverage for a retiree, his or her spouse, and dependents for every three days of annual leave or sick leave, or both, which the employee had accrued as of the effective date of his or her retirement. The remaining premium cost shall be borne by the retired employee if he or she elects the coverage. For purposes of this subsection, an employee who has been a participant under spouse or dependent coverage and who reenters the plan within 12 months after termination of his or her prior coverage shall be considered to have elected to participate in the plan as of the date of commencement of the prior coverage. For purposes of this subsection, an employee shall not be considered a new employee after returning from extended authorized leave on or after July 1, 1988.

(f) In the alternative to the extension of insurance coverage through premium payment provided in subsections (d) and (e) of this section, the accrued annual leave and sick leave of an employee participating in the plan may be applied, on the basis of two days' retirement service credit for each one day of accrued annual and sick leave, toward an increase in the employee's retirement benefits with those days constituting additional credited service in computation of the benefits under any state retirement system: *Provided*, That for a person who first becomes a member of the Teachers Retirement System as provided in §18-7A-1 *et seq*. of this code on or after July 1, 2015, accrued annual and sick leave of an employee participating in the plan may not be applied for retirement service credit: *Provided, however*, That the additional credited service shall not be used in meeting initial eligibility for retirement criteria, but only as additional service credited in excess thereof.

(g) Conversion of accrued annual and sick leave for extended insurance coverage upon retirement for certain higher education employees. Except as otherwise provided in

subsection (k) of this section, when an employee, who is a higher education full-time faculty member employed on an annual contract basis other than for 12 months, is compelled or required by law to retire before reaching the age of 65, or when such a participating employee voluntarily retires as provided by law, that employee's insurance coverage, as provided by this article, shall be extended according to the following formulae: The insurance coverage for a retired higher education full-time faculty member, formerly employed on an annual contract basis other than for 12 months, shall continue beyond the effective date of his or her retirement one additional year for each three and one-third years of teaching service, as determined by uniform guidelines established by the University of West Virginia Board of Trustees and the Board of Directors of the State College System, for individual coverage, or one additional year for each five years of teaching service for family coverage.

(h) Retiree participation. —All retired employees are eligible to obtain health insurance coverage. The retired employee's premium contribution for the coverage shall be established by the finance board.

(i) Surviving spouse and dependent participation. — A surviving spouse and dependents of a deceased employee, who was either an active or retired employee participating in the plan just prior to his or her death, are entitled to be included in any comprehensive group health insurance coverage provided under this article to which the deceased employee was entitled, and the spouse and dependents shall bear the premium cost of the insurance coverage. The finance board shall establish the premium cost of the coverage.

(j) Elected officials. — In construing the provisions of this section or any other provisions of this code, the Legislature declares that it is not now, nor has it ever been the Legislature's intent that elected public officials be provided any sick leave, annual leave, or personal leave, and the enactment of this section is based upon the fact and assumption that no statutory or inherent authority exists extending sick leave, annual leave, or personal leave to elected public officials, and the very nature of those positions preclude the arising or accumulation of any leave so as to be thereafter usable as premium paying credits for which the officials may claim extended insurance benefits.

(k) Participation of certain former employees. — An employee, eligible for coverage under the provisions of this article who has 20 years of service with any agency or entity participating in the public employees insurance program or who has been covered by the public employees insurance program for 20 years may, upon leaving employment with a participating agency or entity, continue to be covered by the program if the employee pays 105 percent of the cost of retiree coverage: *Provided*, That the employee shall elect to continue coverage under this subsection within two years of the date the employment with a participating agency or entity is terminated.

(l) Prohibition on conversion of accrued annual and sick leave for extended coverage upon retirement for new employees who elect to participate in the plan after June, 2001. — Any employee hired on or after July 1, 2001, who elects to participate in the plan may not apply

WV Legislature

accrued annual or sick leave toward the cost of premiums for extended insurance coverage upon his or her retirement. This prohibition does not apply to the conversion of accrued annual or sick leave for increased retirement benefits, as authorized by this section: *Provided*, That any person who has participated in the plan prior to July 1, 2001, is not a new employee for purposes of this subsection if he or she becomes reemployed with an employer participating in the plan within two years following his or her separation from employment and he or she elects to participate in the plan upon his or her reemployment.

(m) Prohibition on conversion of accrued years of teaching service for extended coverage upon retirement for new employees who elect to participate in the plan July, 2009. —Any employee hired on or after July 1, 2009, who elects to participate in the plan may not apply accrued years of teaching service toward the cost of premiums for extended insurance coverage upon his or her retirement.

WV Legislature

§5-16-14. Program qualifying for favorable federal income tax treatment.

The director shall developdeductible and employee premium programs which qualify for favorable federal income tax treatment under section 125 of the Internal Revenue Code.

WV Legislature

§5-16-15. Optional dental, optical, disability, and prepaid retirement plan, and audiology and hearing-aid service plan.

(a) The director shall make available to participants in the public employees insurance system:

(1) A dental insurance plan;

(2) An optical insurance plan;

(3) A disability insurance plan;

(4) A prepaid retirement insurance plan; and

(5) An audiology and hearing-aid services insurance plan.

(b) Public employees insurance participants may elect to participate in any one of these plans separately or in combination. All actuarial and administrative costs of each plan shall be totally borne by the premium payments of the participants or local governing bodies electing to participate in that plan. The director is authorized to employ such administrative practices and procedures with respect to these optional plans as are authorized for the administration of other plans under this article. The director shall establish separate funds for each of the above listed plans. The funds shall not be supplemented by nor be used to supplement any other funds.

WV Legislature

§5-16-16. Preferred provider plan.

The director shall establish a preferred provider system for the delivery of health care to plan participants by all health care providers, which may include, but not be limited to, medical doctors, chiropractors, physicians, osteopathic physicians, surgeons, hospitals, clinics, nursing homes, pharmacies, and pharmaceutical companies.

The director shall establish the terms of the preferred provider system and the incentives therefor. The terms and incentives may include multiyear renewal options as are not prohibited by the Constitution of this state and capitated primary care arrangements which are not subject to the provisions of §33-25A-1 *et seq*. of this code.

WV Legislature

§5-16-17. Preexisting conditions not covered; defined.

A preexisting condition is an injury, or sickness, or any condition relating to that injury, or sickness, for which a participant is diagnosed, receives treatment, or incurs expenses prior to the effective date of coverage.

For all participants enrolling in the plan after the effective date of this section, payment shall be made for expenses incurred for or in connection with a preexisting condition: Provided, That participants may enroll or make plan selections only at the time of hire, during annual open enrollment or upon the occurrence of a "qualifying event" under section 125 of the United States Internal Revenue Code.

WV Legislature

§5-16-18. Payment of costs by employer; schedule of insurance; special funds created; duties of Treasurer with respect thereto.

(a) All employers operating from state general revenue or special revenue funds, or federal funds, or any combination of those funds, shall budget the cost of insurance coverage provided by the Public Employees Insurance Agency to current and retired employees of the employer as a separate line item titled PEIA in its respective annual budget and are responsible for the transfer of funds to the director for the cost of insurance for employees covered by the plan. Each spending unit shall pay to the director its proportionate share from each source of funds. Any agency wishing to charge General Revenue Funds for insurance benefits for retirees under §5-16-13 of this code shall provide documentation to the director that the benefits cannot be paid for by any special revenue account or that the retiring employee has been paid solely with General Revenue Funds for 12 months prior to retirement.

(b) If the general revenue appropriation for any employer, excluding county boards of education, is insufficient to cover the cost of insurance coverage for the employer's participating employees, retired employees, and surviving dependents, the employer shall pay the remainder of the cost from its "personal services" or "unclassified" line items. The amount of the payments for county boards of education shall be determined by the method set forth in §18-9A-24 of this code: *Provided*, That local excess levy funds shall be used only for the purposes for which they were raised: *Provided, however*, That after approval of its annual financial plan, but in no event later than December 31 of each year, the finance board shall notify the Legislature and county boards of education of the maximum amount of employer premiums that the county boards of education shall pay for covered employees during the following fiscal year.

(c) All other employers not operating from the state General Revenue Fund shall pay to the director their share of premium costs from their respective budgets. The finance board shall establish the employers' share of premium costs to reflect and pay the actual costs of the coverage including incurred but not reported claims.

(d) The contribution of the other employers that are counties, cities, or towns in the state; any separate corporation or instrumentality established by one or more counties, cities, or towns, as permitted by law; any corporation or instrumentality supported in most part by counties, cities or towns; any public corporation charged by law with the performance of a governmental function and whose jurisdiction is coextensive with one or more counties, cities, or towns; any comprehensive community mental health center or comprehensive mental health facility established, operated, or licensed pursuant to §27-2A-1 *et seq*. of this code, and which is supported in part by state, county, or municipal funds; and a combined city-county health department created pursuant to §16-2-1 *et seq*. of this code for their employees shall be the percentage of the cost of the employees' insurance package as the employers determine reasonable and proper under their own particular circumstances.

(e) The employee's proportionate share of the premium or cost shall be withheld or deducted

WV Legislature

by the employer from the employee's salary or wages as and when paid and the sums shall be forwarded to the director with any supporting data as the director may require.

(f) All moneys received by the Public Employees Insurance Agency shall be deposited in a special fund or funds as are necessary in the State Treasury and the Treasurer is custodian of the fund or funds and shall administer the fund or funds in accordance with the provisions of this article or as the director may from time to time direct. The Treasurer shall pay all warrants issued by the State Auditor against the fund or funds as the director may direct in accordance with the provisions of this article. All funds received by the agency, shall be deposited, as determined by the director, in any of the investment pools with the West Virginia Investment Management Board, with the interest income or other earnings a proper credit to all such funds for the benefit of the Public Employees Insurance Agency.

(g) The Public Employees Insurance Agency may recover an additional interest amount from any employer that fails to pay in a timely manner any premium or minimum annual employer payment, as defined in §5-16D-1 *et seq*. of this code, which is due and payable to the Public Employees Insurance Agency or the Retiree Health Benefit Trust. The agency may recover the amount due plus an additional amount equal to 2.5 percent per annum of the amount due. Accrual of interest owed by the delinquent employer commences upon the 31st day following the due date for the amount owed and shall continue until receipt by the Public Employees Insurance Agency of the delinquent payment. Interest shall compound every 30 days.

WV Legislature

§5-16-19. Authorization to take advantage of acts of congress, accept gifts, grants and matching funds.

The Public Employees Insurance Agency is authorized to take full advantage of the benefits and provisions of any acts of congress and to accept any and all gifts, grants and matching funds, whether in the form of money or services.

WV Legislature

§5-16-20. Expense fund.

The Legislature shall annually appropriate such sums as may be necessary to pay the proportionate share of the administrative costs for the state as an employer, and each division, agency, board, commission or department of the state which operates out of special revenue funds or federal funds or both shall pay its proportionate share of the administrative costs of the insurance plan or plans authorized under the provisions of this article. All other employers not operating from the state General Revenue Fund shall pay their proportionate share of the administrative costs of the insurance plan or plans authorized under the provisions of this article.

WV Legislature

§5-16-21. No member or employee of public employees insurance agency shall gain directly or indirectly from any contract or contracts provided for hereunder; criminal penalties.

No elected or appointed official of the State of West Virginia; nor any member, officer, or employees of the Legislature; nor any officer, agent, servant or employee in the executive branch of state government shall have any interest, direct or indirect, in the gain or profits arising from any contract or contracts provided for in this article. Any such person who shall gain, directly or indirectly, from any contract or contracts herein provided for, except as an insured beneficiary thereof, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be punished by a fine not exceeding $1,000, or by imprisonment in the county jail for a period not exceeding one year, or by both, in the discretion of the court: Provided, That nothing in this section shall be construed to prohibit an elected or appointed official of this state, nor an employee of the legislative, judicial or executive branches, from providing health care or entering into contracts provided for in section seventeen of this article.

WV Legislature

§5-16-22. Permissive participation; exemptions.

The provisions of this article are not mandatory upon any employee or employer who is not an employee of, or is not, the State of West Virginia, its boards, agencies, commissions, departments, institutions or spending units, or a county board of education, and nothing contained in this article compels any employee or employer to enroll in or subscribe to any insurance plan authorized by the provisions of this article: *Provided,* That nothing in this section requires a public charter school to participate in the Public Employees Insurance Agency program.

Those employees enrolled in the insurance program authorized under the provisions of §21A-2B-1 *et seq.* of this code are not required to enroll in or subscribe to an insurance plan or plans authorized by the provisions of this article, and the employees of any department which has an existing insurance program for its employees to which the government of the United States contributes any part or all of the premium or cost of the premium may be exempted from the provisions of this article. Any employee or employer exempted under the provisions of this paragraph may enroll in any insurance program authorized by the provisions of this article at any time, to the same extent as any other qualified employee or employer, but employee or employer may not remain enrolled in both programs.

Any plan established or administered by the Public Employees Insurance Agency pursuant to this article is exempt from the provisions of chapter 33 of this code unless explicitly stated. Notwithstanding any provision of this code to the contrary, the Public Employees Insurance Agency is not an insurer or engaged in the business of insurance as defined in chapter 33 of this code.

Employers, other than the State of West Virginia, its boards, agencies, commissions, departments, institutions, spending units, or a county board of education, are exempt from participating in the insurance program provided for by the provisions of this article unless participation by the employer has been approved by a majority vote of the employer's governing body. It is the duty of the clerk or secretary of the governing body of an employer who by majority vote becomes a participant in the insurance program to notify the director not later than 10 days after the vote.

Any employer, whether the employer participates in the Public Employees Insurance Agency insurance program as a group or not, which has retired employees, their dependents or surviving dependents of deceased retired employees who participate in the Public Employees Insurance Agency insurance program as authorized by this article, shall pay to the agency the same contribution toward the cost of coverage for its retired employees, their dependents or surviving dependents of deceased retired employees as the State of West Virginia, its boards, agencies, commissions, departments, institutions, spending units, or a county board of education pay for their retired employees, their dependents and surviving dependents of deceased retired employees, as determined by the finance board: *Provided*, That after June 30, 1996, an employer not mandated to participate in the plan is only required to pay a contribution toward the cost of coverage for its retired

employees, their dependents or the surviving dependents of deceased retired employees who elect coverage when the retired employee participated in the plan as an active employee of the employer for at least five years: *Provided, however*, That those retired employees of an employer not participating in the plan who retire on or after July 1, 2010, who have participated in the plan as active employees of the employer for less than five years are responsible for the entire premium cost for coverage and the Public Employees Insurance Agency shall bill for and collect the entire premium from the retired employees, unless the employer elects to pay the employer share of the premium. Each employer is hereby authorized and required to budget for and make such payments as are required by this section.

WV Legislature

§5-16-23. Members of Legislature may be covered if cost of the entire coverage is paid by such members.

Notwithstanding any other provision of this article to the contrary, members of the Legislature may participate in and be covered by any insurance plan or plans authorized hereunder for state officers and employees, except that all members of the Legislature who elect to participate in or to be covered by any such plan or plans shall pay their proportionate individual share of the full cost for all group coverage on themselves, their spouses, and dependents, so that there will be no cost to the state for the coverage of any such members, spouses, and dependents.

WV Legislature

§5-16-24. Rules for administration of article; eligibility of certain retired employees and dependents of deceased members for coverage; employees on medical leave of absence entitled to coverage; life insurance.

The director shall promulgate any necessary rules for the effective administration of the provisions of this article. Except as specifically provided in subsection (e), section four of this article, all rules of the Public Employees Insurance Agency and all hearings held by the Public Employees Insurance Agency are exempt from the provisions of chapter twenty-nine-a of this code. Any rules promulgated by the public employees insurance board or director shall remain in full force and effect until they are amended or replaced by the director.

The rules shall provide that any employee of the state who has been compelled or required by law to retire before reaching the age of sixty-five years is eligible to participate in the public employees' health insurance program at the premium contribution established by the finance board after any extended coverage to which he or she, his or her spouse and dependents may be entitled by virtue of his or her accrued annual leave or sick leave, pursuant to the provisions of section thirteen of this article, has expired. Any employee who voluntarily retires, as provided by law, is eligible to participate in the public employees' health insurance program at the premium contribution established by the finance board after any extended coverage to which he or she, his or her spouse and dependents may be entitled by virtue of his or her accrued annual leave or sick leave, pursuant to the provisions of section thirteen of this article, has expired: Provided, That the employee's last employer is a participating employer. The dependents of any deceased retired employee are entitled to continue their participation and coverage upon payment of the premium contribution established by the finance board. In establishing the cost of health insurance coverage for retired employees and their spouses and dependents, the finance board, in its discretion, may cause the claims experience of the retired employees and their spouses and dependents to be rated separately from that of active employees and their spouses and dependents, or may cause the claims experience of retired and active employees, and their spouses and dependents, to be rated together.

Any employee who is on a medical leave of absence, approved by his or her employer, is subject to the following provisions of this paragraph, is entitled to continue his or her coverage until he or she returns to his or her employment, and the employee and employer shall continue to pay their proportionate share of premium costs as provided by this article: Provided, That the employer is obligated to pay its proportionate share of the premium cost only for a period of one year: Provided, however, That during the period of the leave of absence, the employee shall, at least once each month, submit to the employer the statement of a qualified physician certifying that the employee is unable to return to work.

Any retiree is eligible to participate in the public employees' life insurance program, including the optional life insurance coverage as already available to active employees under this article, at his or her own expense for the cost of coverage, based upon actuarial experience; and the director shall prepare, by rule, for that participation and coverages under declining term insurance and optional additional coverage for the retirees.

§5-16-24a. Paper transactions.

The director may, by rule as authorized in section twenty-four of this article, establish a fee not to exceed $5 per transaction which the Public Employees Insurance Agency may charge to employers for performing business transactions with the agency by paper when the transaction could be performed electronically.

WV Legislature

§5-16-25. Reserve fund.

The finance board shall establish and maintain a reserve fund for the purposes of offsetting unanticipated claim losses in any fiscal year. The finance board shall maintain the actuarily recommended reserve in an amount no less than 10 percent of the projected total plan costs for that fiscal year in the reserve fund, which is to be certified by the actuary and included in the final, approved financial plan submitted to the Governor and Legislature.

WV Legislature

§5-16-26. Quarterly report.

On or before the 30th day of January, April, July, and October the director shall prepare for the approval of the finance board, and thereafter present to the Joint Committee on Government and Finance a quarterly report setting forth:

(a) A summary of the cost to the plan of health care claims incurred in the preceding calendar quarter;

(b) A summary of the funds accrued to the plan by legislative appropriation, employer and employee premiums, or otherwise, in the preceding calendar quarter for payment of health care claims;

(c) An explanation of all cost containment measures, increased premium rates, and any other plan changes adopted by the director in the preceding calendar quarter and estimated cost savings and enhanced revenues resulting therefrom, and a certification that the director made a good faith effort to develop and implement all reasonable health care cost containment alternatives;

(d) Expected claim costs for the next calendar year;

(e) Such other information as the director deems appropriate; and

(f) Any other financial or other information as may be requested by the Joint Committee on Government and Finance.

WV Legislature

§5-16-27.

Repealed.

Acts, 2010 Reg. Sess., Ch. 32.

WV Legislature

§5-16-28. Incorporation of the coverage for 12-month refill for contraceptive drugs.

[Repealed.]

WV Legislature

§5-16-29. Limitation on PEIA participation.

Notwithstanding any other provision of this article to the contrary, the director may not consider any employer eligible for participation in a plan except for the following:

(1) All mandatory participants, including the State of West Virginia, its boards, agencies, commissions, departments, institutions, or spending units.

(2) Any county board of education or public charter school established pursuant to §18- 5G-1 *et seq*. of this code, if the charter school includes in its charter contract entered into pursuant to §18-5G-7 of this code a determination to participate in the Public Employees Insurance program: *Provided,* That as it relates to eligible public charter schools, only employees directly employed by a charter school that is exempt from the payment of taxes under the United States Internal Revenue Code, Title 26 U.S.C. § 501(c)(3), may participate in a plan.

(3) Any employer participating in a plan as of the effective date of the enactment of this section in the regular session of the Legislature, 2021.

WV Legislature

§5-16-30. PEIA solvency.

The Public Employees Insurance Agency shall return to, and provide that, the aggregate premium cost-sharing percentages between employers and employees, including the amounts of any subsidization of retired employee benefits, shall be at a level of 80 percent for the employer and 20 percent for employees during fiscal year 2024 and thereafter.

WV Legislature

§5-16-31. PEIA actuarial study.

PEIA shall conduct an independent actuarial study of the financial solvency of the plan, including, but not limited to, a consideration of alternatives to bring long-term financial stability to the plan, options regarding continued nonstate employee participation in the plan, collapsing salary levels, and any other cost-saving measures. PEIA shall seek input from public employees, retirees, providers, and other interested parties on solutions to evaluate in the study. The actuarial study shall begin on or before July 1, 2023. A report on the study shall be presented to the Joint Committee on Government and Finance on or before July 1, 2024.

WV Legislature

§5-16-32. Effective date of amendments.

The amendments made to this article during the regular session of the Legislature, 2023, shall be incorporated into the plan beginning with plan year 2024.

WV Legislature