

WEST VIRGINIA LEGISLATURE

2022 REGULAR SESSION

ENROLLED

House Bill 4649

BY DELEGATE ROHRBACH

[Passed March 8, 2022; in effect ninety days from passage.]

1 AN ACT to repeal §5-16B-6b, §5-16B-6c, and §5-16B-6e of the Code of West Virginia, 1931, as
2 amended; and to amend and reenact §5-16B-1, §5-16B-2, §5-16B-3, §5-16B-4, §5-16B-
3 5, §5-16B-6, §5-16B-6a, §5-16B-6d, §5-16B-8, §5-16B-9, and §5-16B-10 of said code, all
4 relating to the operation of the West Virginia Children’s Health Insurance Program.

Be it enacted by the Legislature of West Virginia:

ARTICLE 16B. WEST VIRGINIA CHILDREN’S HEALTH INSURANCE PROGRAM.

**§5-16B-1. Expansion of health care coverage to children; continuation of program;
legislative directives.**

1 (a) It is the intent of the Legislature to expand access to health services for eligible children
2 and to pay for this coverage by using private, state, and federal funds to purchase those services
3 or purchase insurance coverage for those services. To achieve this intention, the West Virginia
4 Children’s Health Insurance Program heretofore created shall be continued and administered by
5 the Department of Health and Human Resources, in accordance with the provisions of this article
6 and the applicable provisions of Title XXI of the Social Security Act of 1997: *Provided*, That on
7 and after July 1, 2022, the agencies, boards and programs including all of the allied, advisory,
8 affiliated, or related entities and funds associated with the Children’s Health Insurance Program
9 and Children’s Health Insurance Agency, shall be incorporated in and administered as a part of
10 the Bureau for Medical Services, a division within the Department of Health and Human
11 Resources. Participation in the program may be made available to families of eligible children,
12 subject to eligibility criteria and processes to be established, which does not create an entitlement
13 to coverage in any person. Nothing in this article requires any appropriation of State General
14 Revenue Funds for the payment of any benefit provided in this article. If this article conflicts with
15 the requirements of federal law, federal law governs.

16 (b) In developing a Children’s Health Insurance Program that operates with the highest
17 degree of simplicity and governmental efficiency, the director shall avoid duplicating functions

18 available in existing agencies and may enter into interagency agreements for the performance of
19 specific tasks or duties at a specific or maximum contract price.

20 (c) In developing benefit plans, the director may consider any cost savings, administrative
21 efficiency, or other benefit to be gained by considering existing contracts for services with state
22 health plans and negotiating modifications of those contracts to meet the needs of the program.

23 (d) In order to enroll as many eligible children as possible in the program created by this
24 article and to expedite the effective date of their health insurance coverage, the director shall
25 develop and implement a plan whereby applications for enrollment may be taken at any primary
26 care center or other health care provider, as determined by the director, and transmitted
27 electronically to the program's offices for eligibility screening and other necessary processing.
28 The director may use any funds available to the agency in the development and implementation
29 of the plan, including grant funds or other private or public moneys.

§5-16B-2. Definitions.

1 As used in this article, unless the context clearly requires a different meaning:

2 "Agency" means the Children's Health Insurance Agency, a division within the Bureau for
3 Medical Services.

4 "Board" means the Children's Health Insurance Program Advisory Board.

5 "Commissioner" means the Commissioner of the Bureau for Medical Services appointed
6 by the Secretary of the Department of Health and Human Resources.

7 "Director" means the deputy commissioner within the Bureau for Medical Services who
8 has responsibility for the operation and oversight of the Children's Health Insurance Agency.

9 "Essential community health service provider" means a health care provider that:

10 (1) Has historically served medically needy or medically indigent patients and
11 demonstrates a commitment to serve low-income and medically indigent populations which
12 constitute a significant portion of its patient population or, in the case of a sole community provider,
13 serves medically indigent patients within its medical capability; and

14 (2) Either waives service fees or charges fees based on a sliding scale and does not
15 restrict access or services because of a client's financial limitations. Essential community health
16 service provider includes, but is not limited to, community mental health centers, school health
17 clinics, primary care centers, pediatric health clinics or rural health clinics.

18 "Program" means the West Virginia Children's Health Insurance Program.

§5-16B-3. Reporting requirements.

1 (a) Annually on January 1, the director shall report to the Governor and the Legislature
2 regarding the number of children enrolled in the program; the average annual cost per child per
3 program; the estimated number of remaining uninsured children; and the outreach activities for
4 the previous year. The report shall include any information that can be obtained regarding the
5 prior insurance and health status of the children enrolled in programs created pursuant to this
6 article. The report shall include information regarding the cost, quality, and effectiveness of the
7 health care delivered to enrollees of this program; satisfaction surveys; and health status
8 improvement indicators. The agency, in conjunction with other state health and insurance
9 agencies, shall develop indicators designed to measure the quality and effectiveness of children's
10 health programs, which information shall be included in the annual report.

11 (b) On a quarterly basis, the director shall provide reports to the Legislative Oversight
12 Commission on Health and Human Resources Accountability on the number of children served,
13 including the number of newly enrolled children for the reporting period and current projections
14 for future enrollees; outreach efforts and programs; statistical profiles of the families served and
15 health status indicators of covered children; the average annual cost of coverage per child; the
16 total cost of children served by provider type, service type, and contract type; outcome measures
17 for children served; reductions in uncompensated care; performance with respect to the financial
18 plan; and any other information as the Legislative Oversight Commission on Health and Human
19 Resources Accountability may require.

§5-16B-4. Children’s health policy advisory board created; qualifications and removal of members; powers; duties; meetings; and compensation.

1 (a) There is hereby created the West Virginia children’s health insurance advisory board,
2 which shall consist of the director of the Public Employees Insurance Agency, the secretary of the
3 Department of Health and Human Resources, or his or her designee, and six citizen members
4 appointed by the Governor, one of whom shall represent children’s interests and one of whom
5 shall be a certified public accountant, to assume the duties of the office immediately upon
6 appointment. A member of the Senate, as appointed by the Senate President and a member of
7 the House of Delegates, as appointed by the Speaker of the House of Delegates, shall serve as
8 *ex officio* members. All appointments shall be for terms of three years, except that an appointment
9 to fill a vacancy shall be for the unexpired term only: *Provided*, That the citizen members
10 appointed prior to July 1, 2022, shall serve for the remainder of his or her term of appointment
11 and be deemed a member of the advisory board. Three of the citizen members shall have at least
12 a bachelor’s degree and experience in the administration or design of public or private employee
13 or group benefit programs and the children’s representative shall have experience that
14 demonstrates knowledge in the health, educational, and social needs of children. No more than
15 three citizen members may be members of the same political party and no board member may
16 represent or have a pecuniary interest in an entity reasonably expected to compete for contracts
17 under this article. Members of the board shall assume the duties of the office immediately upon
18 appointment. The director of the agency shall serve as the chairperson of the board. Vacancies
19 in the board shall be filled in the same manner as the original appointment.

20 (b) The purpose of the advisory board is to present recommendations and alternatives for
21 the design of the annual plans and to advise the director with respect to other actions necessary
22 to be undertaken in furtherance of this article.

23 (c) The board shall meet by the call of the director.

24 (d) Each member of the advisory board shall receive reimbursement for reasonable and
25 necessary travel expenses for each day actually served in attendance at meetings of the board
26 in accordance with the state's travel rules. Requisitions for the expenses shall be accompanied
27 by an itemized statement, which shall be filed with the auditor and preserved as a public record.

**§5-16B-5. Director of the Children's Health Insurance Program; qualifications; powers and
duties.**

1 (a) The commissioner shall appoint an individual in the classified service as a deputy
2 commissioner to serve as the director who shall be responsible for the implementation,
3 administration, and management of the Children's Health Insurance Program created under this
4 article. The director shall have at least a bachelor's degree and a minimum of three years'
5 experience in health insurance administration.

6 (b) The director shall employ any administrative, technical, and clerical employees that
7 are required for the proper administration of the program and for the work of the board.

8 (c) The director is responsible for the administration and management of the program and
9 may make all rules necessary to effectuate the provisions of this article. Nothing in this article may
10 be construed as limiting the director's otherwise lawful authority to manage the program on a day-
11 to-day basis.

12 (d) The director may execute any contracts that are necessary to effectuate the provisions
13 of this article. The provisions of §5A-3-1 *et seq.* of this code, relating to the division of purchasing
14 of the department of finance and administration, may not apply to any contracts for any health
15 insurance coverage, health services, or professional services authorized to be executed under
16 the provisions of this article: *Provided*, That before entering into any contract, the director shall
17 invite competitive bids from all qualified entities and shall deal directly with those entities in
18 presenting specifications and receiving quotations for bid purposes. The director shall award
19 those contracts on a competitive basis taking into account the experience of the offering agency,
20 corporation, insurance company, or service organization. Before any proposal to provide benefits

21 or coverage under the plan is selected, the offering agency, corporation, insurance company, or
22 service organization shall provide assurances of utilization of essential community health service
23 providers to the greatest extent practicable. In evaluating these factors, the director may employ
24 the services of independent, professional consultants. The director shall then award the contracts
25 on a competitive basis.

26 (e) The director shall issue requests for proposals on a regional or statewide basis from
27 essential community health service providers for defined portions of services under the children's
28 health insurance plan and shall, to the greatest extent practicable, either contract directly with, or
29 require participating providers to contract with, essential community health service providers to
30 provide the services under the plan.

31 (f) The director may require reinsurance of primary contracts, as contemplated in the
32 provisions of §33-4-15 and §33-4-15a of this code.

§5-16B-6. Financial plans requirements.

1 (a) *Benefit plan design.* — All financial plans required by this section shall establish: (1)
2 the design of a benefit plan or plans; (2) the maximum levels of reimbursement to categories of
3 health care providers; (3) any cost containment measures for implementation during the
4 applicable fiscal year; and (4) the types and levels of cost to families of covered children. To the
5 extent compatible with simplicity of administration, fiscal stability, and other goals of the program
6 established in this article, the financial plans may provide for different levels of costs based on
7 ability to pay.

8 (b) *Annual plans.* — The director shall review implementation of the current financial plan
9 in light of actual experience and shall prepare an annual financial plan for each ensuing fiscal
10 year. The director shall solicit comments in writing from interested and affected persons. The
11 agency shall submit its final, approved financial plan, subject to the actuarial requirements of this
12 article, to the Legislature no later than September 1, preceding the fiscal year. The financial plan
13 for a fiscal year becomes effective and shall be implemented by the director on July 1, of that

14 fiscal year. Annual plans developed pursuant to this subsection are subject to the provisions of
15 subsection (a) of this section and the following guidelines:

16 (1) The aggregate actuarial value of the plan established as the benchmark plan should
17 be considered as a targeted maximum or limitation in developing the benefits package;

18 (2) All estimated program and administrative costs, including incurred but not reported
19 claims, may not exceed 90 percent of the funding available to the program for the applicable fiscal
20 year; and

21 (3) The state's interest in achieving health care services for all its children at less than 200
22 percent of the federal poverty guideline shall take precedence over enhancing the benefits
23 available under this program.

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

26 (d) The director shall review implementation of the current financial plan each quarter
27 and, using actuarial data, shall make those modifications to the plan that are necessary to ensure
28 its fiscal stability and effectiveness of service. The director may not increase the types and levels
29 of cost to families of covered children during the quarterly review except in the event of a true
30 emergency. The agency may not expand the population of children to whom the program is made
31 available except in its annual plan: *Provided*, That upon the effective date of this article, the
32 director may expand coverage to any child eligible under the provisions of Title XXI of the Social
33 Security Act of 1997: *Provided, however*, That the agency shall implement cost-sharing provisions
34 for children who may qualify for the expanded coverage and whose family income exceeds 150
35 percent of the federal poverty guideline. The cost-sharing provisions may be imposed through
36 any one or a combination of the following: enrollment fees, premiums, copayments, and
37 deductibles.

38 (e) The agency may develop and implement programs that provide for family coverage
39 or employer subsidies, or both, within the limits authorized by the provisions of Title XXI of the

40 Social Security Act of 1997 or the federal regulations promulgated thereunder: *Provided*, That any
41 family health insurance coverage offered by or through the program shall be structured so that
42 the agency assumes no financial risk.

§5-16B-6a. Required coverage for patient cost of clinical trials and autism spectrum disorder treatment.

1 Health insurance provided by the program, including coverage provided through a contract
2 with a managed care corporation, shall include coverage of: (i) The patient cost of clinical trials,
3 to the same extent as such coverage is mandated for the public employees insurance program
4 by §5-16-7d and §5-16-7e of this code; and (ii) the diagnosis, evaluation and treatment of autism
5 spectrum disorders for individuals ages 18 months to 18 years, to the same extent as such
6 coverage is mandated for the public employees insurance program by §5-16-7(a)(8) of this code.

§5-16B-6b. Definitions.

1 [Repealed.]

§5-16B-6c. Modified benefit plan for children of families of low income between two hundred and three hundred percent of the poverty level.

1 [Repealed.]

§5-16B-6d. Modified benefit plan implementation.

1 (a) Upon approval by the Centers for Medicare and Medicaid Services, the agency shall
2 implement a benefit plan for uninsured children of families with income between 200 and 300
3 percent of the federal poverty level.

4 (b) The benefit plans offered pursuant to this section shall include services determined to
5 be appropriate for children but may vary from those currently offered by the agency.

6 (c) The agency shall structure the benefit plans for this expansion to include premiums,
7 coinsurance or copays, and deductibles. The agency shall develop the cost-sharing features in
8 such a manner as to keep the program fiscally stable without creating a barrier to enrollment. The

9 features may include different cost-sharing features within this group based upon the percentage
10 of the federal poverty level.

11 All provisions of §5-16B-1 *et seq.* of this code are applicable to this expansion unless
12 expressly addressed in §5-16B-6d of this code.

13 (d) Nothing in §5-16B-6d of this code may be construed to require any appropriation of
14 state general revenue funds for the payment of any benefit provided pursuant to this section,
15 except for the state appropriation used to match the federal financial participation funds. In the
16 event that federal funds are no longer authorized for participation by individuals eligible at income
17 levels above 200 percent, the director shall take immediate steps to terminate the expansion
18 provided for in this section and notify all enrollees of the termination. If federal appropriations
19 decrease for the programs created pursuant to Title XXI of the Social Security Act of 1997, the
20 director shall make those decreases in this expansion program before making changes to the
21 programs created for those children whose family income is less than 200 percent of the federal
22 poverty level.

§5-16B-6e. Coverage for treatment of autism spectrum disorders.

1 [Repealed.]

§5-16B-8. Termination and reauthorization.

1 The program established in this article abrogates and and has no further force and effect,
2 without further action by the Legislature, upon the occurrence of any of the following:

3 (a) The date of entry of a final judgment or order by a court of competent jurisdiction which
4 disallows the program;

5 (b) The effective date of any reduction in annual federal funding levels below the amounts
6 allocated or projected, or both, in Title XXI of the Social Security Act of 1997;

7 (c) The effective date of any federal rule or regulation negating the purposes or effect of
8 this article; or

9 (d) For purposes of subsections (b) and (c) of this section, if a later effective date for
10 reduction or negation is specified, that date shall control.

§5-16B-9. Public-private partnerships.

1 The director may work in conjunction with a nonprofit corporation organized pursuant to
2 the corporate laws of the state, structured to permit qualification pursuant to section 501(c) of the
3 Internal Revenue Code for purposes of assisting the children’s health program and funded from
4 sources other than the state or federal government.

**§5-16B-10. Assignment of rights; right of subrogation by children’s health insurance
agency to the rights of recipients of medical assistance; rules as to effect of
subrogation.**

1 (a) *Definitions.* — As used in this section, unless the context otherwise requires:

2 “Bureau” means the Bureau for Medical Services.

3 “Department” means the West Virginia Department of Health and Human Resources, or
4 its contracted designee.

5 “Recipient” means a person who applies for and receives assistance under the Children’s
6 Health Insurance Program.

7 “Secretary” means the Secretary of the Department of Health and Human Resources.

8 “Third-party” means an individual or entity that is alleged to be liable to pay all or part of
9 the costs of a recipient’s medical treatment and medical-related services for personal injury,
10 disease, illness, or disability, as well as any entity including, but not limited to, a business
11 organization, health service organization, insurer, or public or private agency acting by or on
12 behalf of the allegedly liable third-party.

13 (b) *Assignment of rights.* —

14 (1) Submission of an application to the children’s health insurance agency for medical
15 assistance is, as a matter of law, an assignment of the right of the applicant or his or her legal
16 representative, to recover from third parties past medical expenses paid for by the children’s

17 health insurance program. This assignment of rights does not extend to Medicare benefits. At the
18 time the application is made, the children's health insurance agency shall include a statement
19 along with the application that explains that the applicant has assigned all of his or her rights as
20 provided in this section and the legal implications of making this assignment.

21 (2) This section does not prevent the recipient or his or her legal representative from
22 maintaining an action for injuries or damages sustained by the recipient against any third party
23 and from including, as part of the compensatory damages sought to be recovered, the amount or
24 amounts of his or her medical expenses.

25 (3) The department shall be legally subrogated to the rights of the recipient against the
26 third party.

27 (4) The department shall have a priority right to be paid first out of any payments made to
28 the recipient for past medical expenses before the recipient can recover any of his or her own
29 costs for medical care.

30 (5) A recipient is considered to have authorized all third parties to release to the
31 department information needed by the department to secure or enforce its rights as assignee
32 under this article.

33 (c) *Notice requirement for claims and civil actions.* —

34 (1) A recipient's legal representative shall provide notice to the department within 60 days
35 of asserting a claim against a third party. If the claim is asserted in a formal civil action, the
36 recipient's legal representative shall notify the department within 60 days of service of the
37 complaint and summons upon the third party by causing a copy of the summons and a copy of
38 the complaint to be served on the department as though it were named a party defendant.

39 (2) If the recipient has no legal representative and the third party knows or reasonably
40 should know that a recipient has no representation then the third party shall provide notice to the
41 department within 60 days of receipt of a claim or within 30 days of receipt of information or

42 documentation reflecting the recipient is receiving children's health insurance program benefits,
43 whichever is later in time.

44 (3) In any civil action implicated by this section, the department may file a notice of
45 appearance and shall thereafter have the right to file and receive pleadings, intervene, and take
46 other action permitted by law.

47 (4) The department shall provide the recipient and the third party, if the recipient is without
48 legal representation, notice of the amount of the purported subrogation lien within 30 days of
49 receipt of notice of the claim. The department shall provide related supplements in a timely
50 manner, but no later than 15 days after receipt of a request for same.

51 (d) *Notice of settlement requirement.* —

52 (1) A recipient or his or her representative shall notify the department of a settlement with
53 a third party and retain in escrow an amount equal to the amount of the subrogation lien asserted
54 by the department. The notification shall include the amount of the settlement being allocated for
55 past medical expenses paid for by the Medicaid program. Within 30 days of the receipt of any
56 such notice, the department shall notify the recipient of its consent or rejection of the proposed
57 allocation. If the department consents, the recipient or his or her legal representation shall issue
58 payment out of the settlement proceeds in a manner directed by the secretary or his or her
59 designee within 30 days of consent to the proposed allocation.

60 (2) If the total amount of the settlement is less than the department's subrogation lien, then
61 the settling parties shall obtain the department's consent to the settlement before finalizing the
62 settlement. The department shall advise the parties within 30 days and provide a detailed
63 itemization of all past medical expenses paid by the department on behalf of the recipient for
64 which the department seeks reimbursement out of the settlement proceeds.

65 (3) If the department rejects the proposed allocation, the department shall seek a judicial
66 determination within 30 days and provide a detailed itemization of all past medical expenses paid

67 by the department on behalf of the recipient for which the department seeks reimbursement out
68 of the settlement proceeds.

69 (A) If judicial determination becomes necessary, the trial court is required to hold an
70 evidentiary hearing. The recipient and the department shall be provided ample notice of the same
71 and be given just opportunity to present the necessary evidence, including fact witness and expert
72 witness testimony, to establish the amount to which the department is entitled to be reimbursed
73 pursuant to this section.

74 (B) The department has the burden of proving by a preponderance of the evidence that
75 the allocation agreed to by the parties was improper. For purposes of appeal, the trial court's
76 decision should be set forth in a detailed order containing the requisite findings of fact and
77 conclusions of law to support its rulings.

78 (4) Any settlement by a recipient with one or more third parties which would otherwise fully
79 resolve the recipient's claim for an amount collectively not to exceed \$20,000 shall be exempt
80 from the provisions of this section.

81 (5) Nothing herein prevents a recipient from seeking judicial intervention to resolve any
82 dispute as to allocation prior to effectuating a settlement with a third party.

83 (e) *Department failure to respond to notice of settlement.* — If the department fails to
84 appropriately respond to a notification of settlement, the amount to which the department is
85 entitled to be paid from the settlement shall be limited to the amount of the settlement the recipient
86 has allocated toward past medical expenses.

87 (f) *Penalty for failure to notify the department.* — A legal representative acting on behalf
88 of a recipient or third party that fails to comply with the provisions of this section is liable to the
89 department for all reimbursement amounts the department would otherwise have been entitled to
90 collect pursuant to this section but for the failure to comply. Under no circumstances may a *pro*
91 *se* recipient be penalized for failing to comply with the provisions of this section.

92 (g) *Miscellaneous provisions relating to trial.* —

93 (1) Where an action implicated by this section is tried by a jury, the jury may not be
94 informed at any time as to the subrogation lien of the department.

95 (2) Where an action implicated by this section is tried by judge or jury, the trial judge shall,
96 or in the instance of a jury trial, require that the jury precisely identify the amount of the verdict
97 awarded that represents past medical expenses.

98 (3) Upon the entry of judgment on the verdict, the court shall direct that upon satisfaction
99 of the judgment any damages awarded for past medical expenses be withheld and paid directly
100 to the department, not to exceed the amount of past medical expenses paid by the department
101 on behalf of the recipient.

102 (h) *Attorneys' fees.* — Irrespective of whether an action or claim is terminated by judgment
103 or settlement without trial, from the amount required to be paid to the department there shall be
104 deducted the reasonable costs and attorneys' fees attributable to the amount in accordance with
105 and in proportion to the fee arrangement made between the recipient and his or her attorney of
106 record so that the department shall bear the pro-rata share of the reasonable costs and attorneys'
107 fees: *Provided*, That if there is no recovery, the department may under no circumstances be liable
108 for any costs or attorneys' fees expended in the matter.

109 (i) *Class actions and multiple plaintiff actions not authorized.* — Nothing in this article
110 authorizes the department to institute a class action or multiple plaintiff action against any
111 manufacturer, distributor, or vendor of any product to recover medical care expenditures paid for
112 by the Medicaid program.

113 (j) *Secretary's authority.* — The secretary or his or her designee may compromise, settle,
114 and execute a release of any claim relating to the department's right of subrogation, in whole or
115 in part.

The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

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Chairman, House Committee

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Chairman, Senate Committee

Originating in the House.

In effect ninety days from passage.

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Clerk of the House of Delegates

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Clerk of the Senate

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Speaker of the House of Delegates

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President of the Senate

The within this the.....
day of, 2022.

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Governor