

WEST VIRGINIA LEGISLATURE

2023 REGULAR SESSION

Committee Substitute

for

Committee Substitute

for

Senate Bill 268

By Senators Takubo, Hamilton, Queen, Plymale,

Deeds, and Nelson

[Originating in the Committee on Finance; reported on

February 22, 2023]

1 A BILL to amend and reenact §5-16-2, §5-16-3, §5-16-4, §5-16-5, §5-16-7, §5-16-7b, §5-16-7c,
2 §5-16-7g, §5-16-8, §5-16-9, §5-16-10, §5-16-11, §5-16-13, §5-16-14, §5-16-15, §5-16-16,
3 §5-16-18, §5-16-23, §5-16-25, and §5-16-26 of the Code of West Virginia, 1931, as
4 amended; to repeal §5-16-5b and §5-16-28 of said code; and to amend said code by
5 adding thereto three new sections, designated §5-16-30, §5-16-31, and §5-16-32, all
6 relating to the West Virginia Public Employees Insurance Act.

Be it enacted by the Legislature of West Virginia:

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES' INSURANCE ACT.

§5-16-2. Definitions.

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

3 (1) "Agency" or "PEIA" means the Public Employees Insurance Agency created by this
4 article.

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

9 "Autism spectrum disorder" means any pervasive developmental disorder, including
10 autistic disorder, Asperger's syndrome, Rett syndrome, childhood disintegrative disorder, or
11 Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and
12 Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

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

17 (2) "Director" means the Director of the Public Employees Insurance Agency created by

18 this article.

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

21 (3) "Employee" means any person, including an elected officer, who works regularly full-
22 time in the service of the State of West Virginia; and, for the purpose of this article only, the term
23 "employee" also means any person, including an elected officer, who works regularly full-time in
24 the service of a county board of education; a public charter school established pursuant to §18-
25 5G-1 *et seq.* of this code if the charter school includes in its charter contract entered into pursuant
26 to §18-5G-7 of this code a determination to participate in the Public Employees Insurance
27 program; a county, city, or town in the ~~State~~ state; any separate corporation or instrumentality
28 established by one or more counties, cities, or towns, as permitted by law; any corporation or
29 instrumentality supported in most part by counties, cities, or towns; any public corporation charged
30 by law with the performance of a governmental function and whose jurisdiction is coextensive with
31 one or more counties, cities, or towns; any comprehensive community mental health center or
32 intellectually and developmentally disabled facility established, operated, or licensed by the
33 Secretary of the Department of Health and Human Resources pursuant to §27-2A-1 of this code
34 and which is supported in part by state, county, or municipal funds; any person who works
35 regularly full-time in the service of the Higher Education Policy Commission, the West Virginia
36 Council for Community and Technical College Education, or a governing board as defined in §18B-
37 1-2 of this code; any person who works regularly full-time in the service of a combined city-county
38 health department created pursuant to §16-2-1 *et seq.* of this code; any person designated as a
39 21st Century Learner Fellow pursuant to §18A-3-11 of this code; and any person who works as a
40 long-term substitute as defined in §18A-1-1 of this code in the service of a county board of
41 education: *Provided*, That a long-term substitute who is continuously employed for at least 133
42 instructional days during an instructional term, and, until the end of that instructional term, is
43 eligible for the benefits provided in this article until September 1 following that instructional

44 term: *Provided, however,* That a long-term substitute employed fewer than 133 instructional days
45 during an instructional term is eligible for the benefits provided in this article only during such time
46 as he or she is actually employed as a long-term substitute. On and after January 1, 1994, and
47 upon election by a county board of education to allow elected board members to participate in the
48 Public Employees Insurance Program pursuant to this article, any person elected to a county
49 board of education shall be considered to be an "employee" during the term of office of the elected
50 member. Upon election by the ~~state~~ State Board of Education to allow appointed board members
51 to participate in the Public Employees Insurance Program pursuant to this article, any person
52 appointed to the ~~state~~ State Board of Education is considered an "employee" during the term of
53 office of the appointed member: *Provided further,* That the elected member of a county board of
54 education and the appointed member of the ~~state~~ State Board of Education shall pay the entire
55 cost of the premium if he or she elects to be covered under this article. Any matters of doubt as to
56 who is an employee within the meaning of this article shall be decided by the director.

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

59 (A) Participates in a job-sharing arrangement as defined in §18A-1-1 of this code;

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

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

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

70 corporation charged by law with the performance of a governmental function and whose
71 jurisdiction is coextensive with one or more counties, cities, or towns; any comprehensive
72 community mental health center or intellectually and developmentally disabled facility established,
73 operated, or licensed by the Secretary of the Department of Health and Human Resources
74 pursuant to §27-2A-1 of this code and which is supported in part by state, county, or municipal
75 funds; a combined city-county health department created pursuant to §16-2-1 *et seq.* of this code;
76 and a corporation meeting the description set forth in §18B-12-3 of this code that is employing a
77 21st Century Learner Fellow pursuant to §18A-3-11 of this code but the corporation is not
78 considered an employer with respect to any employee other than a 21st Century Learner Fellow.
79 Any matters of doubt as to who is an "employer" within the meaning of this article shall be decided
80 by the director. The term "employer" does not include within its meaning the National Guard.

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

85 (5) "Finance board" means the Public Employees Insurance Agency finance board created
86 by this article.

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

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

95 "Objective evidence" means standardized patient assessment instruments, outcome

96 measurements tools, or measurable assessments of functional outcome. Use of objective
97 measures at the beginning of treatment, during, and after treatment is recommended to quantify
98 progress and support justifications for continued treatment. The tools are not required but their use
99 will enhance the justification for continued treatment.

100 (6) "Person" means any individual, company, association, organization, corporation, or
101 other legal entity. ~~including, but not limited to, hospital, medical or dental service corporations;~~
102 ~~health maintenance organizations or similar organization providing prepaid health benefits; or~~
103 ~~individuals entitled to benefits under the provisions of this article~~

104 (7) "Plan" ~~unless the context indicates otherwise, means the medical indemnity plan, the~~
105 ~~managed care plan option, or the group life insurance plan offered by the agency. a group hospital~~
106 and surgical insurance plan or plans, a group prescription drug insurance plan or plans, a group
107 major medical insurance plan or plans, and a group life and accidental death insurance plan or
108 plans.

109 "Prescription insulin drug" means a prescription drug that contains insulin and is used to
110 treat diabetes, and includes at least one type of insulin in all of the following categories:

- 111 (1) Rapid-acting;
- 112 (2) Short-acting;
- 113 (3) Intermediate-acting;
- 114 (4) Long-acting;
- 115 (5) Pre-mixed insulin products;
- 116 (6) Pre-mixed insulin/GLP-1 RA products; and
- 117 (7) Concentrated human regular insulin.

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

121 "Remote patient monitoring services" means the delivery of home health services using

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

126 (8) "Retired employee" means an employee of the state who retired after April 29, 1971,
127 and an employee of the Higher Education Policy Commission, the Council for Community and
128 Technical College Education, a state institution of higher education, or a county board of education
129 who retires on or after April 21, 1972, and all additional eligible employees who retire on or after
130 the effective date of this article, meet the minimum eligibility requirements for their respective state
131 retirement system, and whose last employer immediately prior to retirement under the state
132 retirement system is a participating employer in the state retirement system and in the Public
133 Employees Insurance Agency: *Provided*, That for the purposes of this article, the employees who
134 are not covered by a state retirement system, but who are covered by a state-approved or state-
135 contracted retirement program or a system approved by the director, shall, in the case of education
136 employees, meet the minimum eligibility requirements of the State Teachers Retirement System,
137 and in all other cases, meet the minimum eligibility requirements of the Public Employees
138 Retirement System and may participate in the Public Employees Insurance Agency as retired
139 employees upon terms as the director sets by rule as authorized in this article. Employers with
140 employees who are, or who are eligible to become, retired employees under this article shall be
141 mandatory participants in the Retiree Health Benefit Trust Fund created pursuant to §5-16D-1 *et*
142 *seq.* of this code. Nonstate employers may opt out of the West Virginia other post-employment
143 benefits plan of the Retiree Health Benefit Trust Fund and elect to not provide benefits under the
144 Public Employees Insurance Agency to retirees of the nonstate employer, but may do so only upon
145 the written certification, under oath, of an authorized officer of the employer that the employer has
146 no employees who are, or who are eligible to become, retired employees and that the employer
147 will defend and hold harmless the Public Employees Insurance Agency from any claim by one of

148 the employer's past, present, or future employees for eligibility to participate in the Public
149 Employees Insurance Agency as a retired employee. As a matter of law, the Public Employees
150 Insurance Agency shall not be liable in any respect to provide plan benefits to a retired employee
151 of a nonstate employer which has opted out of the West Virginia other post-employment benefits
152 plan of the Retiree Health Benefit Trust Fund pursuant to this section.

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

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

**§5-16-3. Composition of Public Employees Insurance Agency; ~~appointment, qualifications,~~
~~compensation and duties of director of agency; employees; civil service coverage.~~**

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

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

15 (c) The director is responsible for the administration and management of the Public
16 Employees Insurance Agency as provided in this article and in connection with his or her
17 responsibility may make all rules necessary to effectuate the provisions of this article. Nothing in
18 §5-16-4 or §5-16-5 of this code limits the director's ability to manage on a day-to-day basis the
19 group insurance plans required or authorized by this article, including, but not limited to,
20 administrative contracting, studies, analyses and audits, eligibility determinations, utilization
21 management provisions and incentives, provider negotiations, provider contracting and payment,
22 designation of covered and noncovered services, offering of additional coverage options or cost
23 containment incentives, pursuit of coordination of benefits, and subrogation, or any other actions
24 which would serve to implement the plan or plans designed by the finance board. The director is to
25 function as a benefits management professional and should avoid political involvement in
26 managing the affairs of the Public Employees Insurance Agency.

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

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

37 (1) Increasing generic fill rates;

- 38 (2) Managing specialty pharmacy costs;
- 39 (3) Implementing and evaluating medical home models and health care delivery;
- 40 (4) Coordinating with providers, private insurance carriers, and, to the extent possible,
41 Medicare to encourage the establishment of cost-effective accountable care organizations;
- 42 (5) Exploring and developing advanced payment methodologies for care delivery such as
43 case rates, capitation, and other potential risk-sharing models and partial risk-sharing models for
44 accountable care organizations and/or medical homes;
- 45 (6) Adopting measures identified by the Centers for Medicare and Medicaid Services to
46 reduce cost and enhance quality;
- 47 (7) Evaluating the expenditures to reduce excessive use of emergency room visits,
48 imaging services, and other drivers of the agency's medical rate of inflation;
- 49 (8) Recommending cutting-edge benefit designs to the finance board to drive behavior and
50 control costs for the plans;
- 51 (9) Implementing programs to encourage the use of the most efficient and high-quality
52 providers by employees and retired employees;
- 53 (10) Identifying employees and retired employees who have multiple chronic illnesses and
54 initiating programs to coordinate the care of these patients;
- 55 (11) Initiating steps ~~by the agency~~ to adjust payment by the agency for the treatment of
56 hospital-acquired infections and related events consistent with the payment policies, operational
57 guidelines, and implementation timetable established by the Centers of Medicare and Medicaid
58 Services. The agency shall protect employees and retired employees from any adjustment in
59 payment for hospital acquired infections; and
- 60 (12) Initiating steps ~~by the agency~~ to reduce the number of employees and retired
61 employees who experience avoidable readmissions to a hospital for the same diagnosis-related
62 group illness within 30 days of being discharged by a hospital in this state or another state
63 consistent with the payment policies, operational guidelines, and implementation timetable

64 established by the Centers of Medicare and Medicaid Services.

65 ~~(f) The director shall issue an annual progress report to the Joint Committee on~~
66 ~~Government and Finance on the implementation of any reforms initiated pursuant to this section~~
67 ~~and other initiatives developed by the agency~~

§5-16-4. Public Employees Insurance Agency Finance Board continued; qualifications, terms, and removal of members; quorum; compensation and expenses; termination date.

1 (a) The Public Employees Insurance Agency Finance Board is continued and consists of
2 the Secretary of the Department of Administration or his or her designee, as a voting member, and
3 10 members appointed by the Governor, with the advice and consent of the Senate, for terms of
4 four years and each may serve until his or her successor is appointed and qualified. Members may
5 be reappointed for successive terms. No more than six members, including the Secretary of the
6 Department of Administration, may be of the same political party. ~~Effective July 1, 2017, Members~~
7 ~~of the board shall satisfy the qualification requirements provided for by subsection (b) of this~~
8 ~~section. *Provided*, That any member serving upon the effective date of this section who does not~~
9 ~~satisfy a requirement of subsection (b) of this section may continue to serve until his or her~~
10 ~~successor has been appointed and qualified~~ The Governor shall make appointments necessary to
11 satisfy the requirements of subsection (b) of this section to staggered terms as determined by the
12 Governor.

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

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

19 (B) One member shall represent the interests of public employees. The member shall be

20 employed to perform full- or part-time service for wages, salary, or remuneration for a public body
21 for a period of at least three years prior to his or her appointment and shall remain an employee of
22 a public body for the duration of his or her appointment to remain eligible to serve on the board.

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

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

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

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

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

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

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

45 (iii) One member selected from the public at large shall be a certified public accountant with

46 at least three years of experience with financial management and employee benefits program
47 experience; and

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

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

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

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

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

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

68 (d) Upon termination of the board and notwithstanding any provisions of this article to the
69 contrary, the director is authorized to assess monthly employee premium contributions and to
70 change the types and levels of costs to employees only in accordance with this subsection. Any
71 assessments or changes in costs imposed pursuant to this subsection shall be implemented by

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

**§5-16-5. Purpose, Powers and duties of the finance board; ~~initial finance plan; financial~~
~~plan for following year; and annual financial plans.~~**

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

7 (b) The finance board shall retain the services of an impartial, professional actuary, with
8 demonstrated experience in analysis of large group health insurance plans, to estimate the total
9 financial requirements of the Public Employees Insurance Agency for each fiscal year and to
10 review and render written professional opinions as to financial plans proposed by the finance
11 board. The actuary shall also assist in the development of alternative financing options and
12 perform any other services requested by the finance board or the director. All reasonable fees and
13 expenses for actuarial services shall be paid by the Public Employees Insurance Agency. Any
14 financial plan or modifications to a financial plan approved or proposed by the finance board
15 ~~pursuant to this section~~ shall be submitted to and reviewed by the actuary and may not be finally
16 approved and submitted to the Governor and to the Legislature without the actuary's written
17 professional opinion that the plan may be reasonably expected to generate sufficient revenues to
18 meet all estimated program and administrative costs of the agency, including incurred but
19 unreported claims, for the fiscal year for which the plan is proposed. ~~The actuary's opinion on the~~
20 ~~financial plan for each fiscal year shall allow for no more than thirty days of accounts payable to be~~
21 ~~carried over into the next fiscal year. The actuary's opinion for any fiscal year shall not include a~~

22 ~~requirement for establishment of a reserve fund~~

23 (c) All financial plans ~~required by this section~~ shall establish:

24 (1) ~~Maximum levels of reimbursement which the Public Employees Insurance Agency~~
25 ~~makes to categories of health care providers~~ The minimum level of reimbursement at 110 percent
26 of the Medicare amount for all providers: *Provided, That the plan shall reimburse a West Virginia*
27 hospital that provides inpatient medical care to a beneficiary, covered by the state and non-state
28 plans, at a minimum rate of 110 percent of the Medicare diagnosis-related group rate for the
29 admission, or the Medicare per diem, per day rate applicable to a critical access hospital, as
30 appropriate: *Provided, however, That the rates established pursuant to this subdivision do not*
31 apply to any Medicare primary retiree health plan.

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

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

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

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

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

44 (d)(1) The finance board shall prepare an annual financial plan for each fiscal year. ~~during~~
45 ~~which the finance board remains in existence~~ The finance board chairman shall request the
46 actuary to estimate the total financial requirements of the Public Employees Insurance Agency for
47 the fiscal year.

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

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

63 (4) ~~Any financial plan shall be designed to allow thirty days or less of accounts payable to~~
64 ~~be carried over into the next fiscal year.~~ For each fiscal year, the Governor shall provide his or her
65 estimate of total revenues to the finance board no later than October 15 of the preceding fiscal
66 year: *Provided*, That for the prospective financial plans required by this section, the Governor shall
67 estimate the revenues available for each fiscal year of the plans based on the estimated
68 percentage of growth in general fund revenues: *Provided, however*, That the director and finance
69 board may only use revenue estimates from the Governor as necessary to maintain an actuarially
70 recommended reserve fund and to maintain premium cost-sharing percentages as required in this
71 article: *Provided further*, That the director and finance board may not incorporate revenue sources
72 into the finance board plan beyond the premium cost-sharing percentages as required in this
73 article. The director shall provide the number of covered lives for the current fiscal year and a five-

74 year analysis of the costs for covering paid claims to the finance board no later than October 15 for
75 the preceding year. The finance board shall submit its final approved financial plan after obtaining
76 the necessary actuary's opinion, which opinion shall include, but not be limited to, the aggregate
77 premium cost-sharing percentages between employers and employees, including the amounts of
78 any subsidization of retired employee benefits, at a level of 80 percent for the employer and 20
79 percent for employees, and conducting one or more public hearings in each congressional district
80 to the Governor and to the Legislature no later than January 1 preceding the fiscal year. The
81 financial plan for a fiscal year becomes effective and shall be implemented by the director on July 1
82 of the fiscal year. In addition to each final approved financial plan required under this section, the
83 finance board shall also simultaneously submit financial statements based on generally accepted
84 accounting practices (GAAP) and the final approved plan restated on an accrual basis of
85 accounting, which shall include allowances for incurred but not reported claims. *Provided,*
86 *however,* That The financial statements and the accrual-based financial plan restatement shall not
87 affect the approved financial plan.

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

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

96 (g) The prospective financial plans shall be based on the estimated revenues submitted in
97 accordance §5-16-5(d)(4) of this code and shall include an average of the projected cost-sharing
98 percentages of premiums and an average of the projected deductibles and copays for the various
99 programs. ~~Beginning in the plan year which commences on July 1, 2002, and in each plan year~~

100 ~~thereafter, until and including the plan year which commences on July 1, 2006, the prospective~~
101 ~~plans shall include incremental adjustments toward the ultimate level required in this subsection,~~
102 ~~in the aggregate cost-sharing percentages of premium between employers and employees,~~
103 ~~including the amounts of any subsidization of retired employee benefits. Effective in the plan year~~
104 ~~commencing on July 1, 2006, and in Each plan year, thereafter the aggregate premium cost-~~
105 ~~sharing percentages between employers and employees, including the amounts of any~~
106 ~~subsidization of retired employee benefits, shall be at a level of 80 percent for the employer and 20~~
107 ~~percent for employees, except for the employers provided in §5-16-18(d) of this code whose~~
108 ~~premium cost-sharing percentages shall be governed by that subsection. After the submission of~~
109 ~~the initial prospective plan, the board may not increase costs to the participating employers or~~
110 ~~change the average of the premiums, deductibles, and copays for employees, except in the event~~
111 ~~of a true emergency. as provided in this section: *Provided*, That If the board invokes the~~
112 ~~emergency provisions, the cost shall be borne between the employers and employees in~~
113 ~~proportion to the cost-sharing ratio for that plan year. *Provided, however*, That For purposes of this~~
114 ~~section, "emergency" means that the most recent projections demonstrate that plan expenses will~~
115 ~~exceed plan revenues by more than one percent in any plan year. *Provided further*, That The~~
116 ~~aggregate premium cost-sharing percentages between employers and employees, including the~~
117 ~~amounts of any subsidization of retired employee benefits, may be offset, in part, by a legislative~~
118 ~~appropriation for that purpose.~~

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

126 (i) For any fiscal year in which legislative appropriations differ from the Governor's estimate
127 of general and special revenues available to the agency, the finance board shall, within 30 days
128 after passage of the budget bill, make any modifications to the plan necessary to ensure that the
129 total financial requirements of the agency for the current fiscal year are met.

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

[Repealed.]

§5-16-7. Authorization to establish ~~group hospital and surgical insurance plan, group major medical insurance plan, group drug prescription plans, and group life and accidental death insurance plan; rules for administration of plans plans; mandated benefits; optional plans; separate rating for claims experience purposes.~~

1 (a) The agency shall establish ~~a group hospital and surgical insurance plan or plans, a~~
2 ~~group prescription drug insurance plan or plans, a group major medical insurance plan or plans,~~
3 ~~and a group life and accidental death insurance plan or plans~~ for those employees herein made
4 eligible and establish and promulgate rules for the administration of these plans subject to the
5 limitations contained in this article. These plans shall include:

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

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

16 (3) Annual screening for kidney disease as determined to be medically necessary by a

17 physician using any combination of blood pressure testing, urine albumin or urine protein testing,
18 and serum creatinine testing as recommended by the National Kidney Foundation;

19 (4) For plans that include maternity benefits, coverage for inpatient care in a duly licensed
20 health care facility for a mother and her newly born infant for the length of time which the attending
21 physician considers medically necessary for the mother or her newly born child. No plan may deny
22 payment for a mother or her newborn child prior to 48 hours following a vaginal delivery or prior to
23 96 hours following a caesarean section delivery if the attending physician considers discharge
24 medically inappropriate;

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

31 (6) Coverage for treatment of serious mental illness:

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

36 (i) Schizophrenia and other psychotic disorders;

37 (ii) Bipolar disorders;

38 (iii) Depressive disorders;

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

41 (v) Anxiety disorders; and

42 (vi) Anorexia and bulimia.

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

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

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

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

69 (B) A child who is 12 years of age or younger with documented phobias or with
70 documented mental illness and with dental needs of such magnitude that treatment should not be
71 delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of
72 teeth, or other increased oral or dental morbidity and for whom a successful result cannot be
73 expected from dental care provided under local anesthesia because of such condition and for
74 whom a superior result can be expected from dental care provided under general anesthesia.

75 (8) (A) ~~Any plan issued or renewed on or after January 1, 2012, shall include coverage for~~
76 All plans shall include coverage for diagnosis, evaluation, and treatment of autism spectrum
77 disorder in individuals ages 18 months to 18 years. To be eligible for coverage and benefits under
78 this subdivision, the individual must be diagnosed with autism spectrum disorder at age eight or
79 younger. Such plan shall provide coverage for treatments that are medically necessary and
80 ordered or prescribed by a licensed physician or licensed psychologist and in accordance with a
81 treatment plan developed from a comprehensive evaluation by a certified behavior analyst for an
82 individual diagnosed with autism spectrum disorder.

83 (B) The coverage shall include, but not be limited to, applied behavior analysis which shall
84 be provided or supervised by a certified behavior analyst. ~~The annual maximum benefit for applied~~
85 ~~behavior analysis required by this subdivision shall be in an amount not to exceed \$30,000 per~~
86 ~~individual for three consecutive years from the date treatment commences. At the conclusion of~~
87 ~~the third year, coverage for applied behavior analysis required by this subdivision shall be in an~~
88 ~~amount not to exceed \$2,000 per month, until the individual reaches 18 years of age, as long as~~
89 ~~the treatment is medically necessary and in accordance with a treatment plan developed by a~~
90 ~~certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual~~
91 This subdivision does not limit, replace, or affect any obligation to provide services to an individual
92 under the Individuals with Disabilities Education Act, 20 U. S. C. §1400 *et seq.*, as amended from
93 time to time, or other publicly funded programs. Nothing in this subdivision requires
94 reimbursement for services provided by public school personnel.

95 (C) The certified behavior analyst shall file progress reports with the agency semiannually.

96 In order for treatment to continue, the agency must receive objective evidence or a clinically
97 supportable statement of expectation that:

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

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

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

102 ~~(D) On or before January 1 each year, the agency shall file an annual report with the Joint
103 Committee on Government and Finance describing its implementation of the coverage provided
104 pursuant to this subdivision. The report shall include, but not be limited to, the number of
105 individuals in the plan utilizing the coverage required by this subdivision, the fiscal and
106 administrative impact of the implementation and any recommendations the agency may have as
107 to changes in law or policy related to the coverage provided under this subdivision. In addition, the
108 agency shall provide such other information as required by the Joint Committee on Government
109 and Finance as it may request.~~

110 (E) For purposes of this subdivision, the term:

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

115 (ii) ~~"Autism spectrum disorder" means any pervasive developmental disorder including
116 autistic disorder, Asperger's syndrome, Rett syndrome, childhood disintegrative disorder, or
117 Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and
118 Statistical Manual of Mental Disorders of the American Psychiatric Association.~~

119 (iii) ~~"Certified behavior analyst" means an individual who is certified by the Behavior
120 Analyst Certification Board or certified by a similar nationally recognized organization.~~

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

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

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

138 (10) (A) ~~A policy, plan, or contract that is issued or renewed on or after January 1, 2019,~~
139 ~~and that is subject to this section, shall provide Coverage, through the age of 20, for amino acid-~~
140 ~~based formula for the treatment of severe protein-allergic conditions or impaired absorption of~~
141 ~~nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the~~
142 ~~gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder~~
143 ~~by a physician licensed to practice in this state pursuant to either §30-3-1 et seq. or §30-14-1 et~~
144 ~~seq. of this code:~~

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

- 147 (ii) Severe food protein-induced enterocolitis syndrome;
148 (iii) Eosinophilic disorders as evidenced by the results of a biopsy; and
149 (iv) Impaired absorption of nutrients caused by disorders affecting the absorptive surface,
150 function, length, and motility of the gastrointestinal tract (short bowel).

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

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

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

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

170 (12) The provision requiring coverage for 12-month refill for contraceptive drugs codified at
171 §33-58-1 of this code.

172 (13) The group life and accidental death insurance herein provided shall be in the amount

173 of \$10,000 for every employee.

174 (b) The agency shall ~~with full authorization~~ make available to each eligible employee, at full
175 cost to the employee, the opportunity to purchase optional group life and accidental death
176 insurance as established under the rules of the agency. In addition, each employee is entitled to
177 have his or her spouse and dependents, as defined by the rules of the agency, included in the
178 optional coverage, at full cost to the employee, for each eligible dependent.

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

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

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

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

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

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

192 (e) The agency shall establish procedures to authorize treatment with a nonparticipating
193 provider if a covered service is not available within established time and distance standards and
194 within a reasonable period after service is requested, and with the same coinsurance, deductible,
195 or copayment requirements as would apply if the service were provided at a participating provider,
196 and at no greater cost to the covered person than if the services were obtained at or from a
197 participating provider.

198 (f) If the Public Employees Insurance Agency offers a plan that does not cover services

199 provided by an out-of-network provider, it may provide the benefits required in paragraph (A),
200 subdivision (6), subsection (a) of this section if the services are rendered by a provider who is
201 designated by and affiliated with the Public Employees Insurance Agency, and only if the same
202 requirements apply for services for a physical illness.

203 (g) In the event of a concurrent review for a claim for coverage of services for the
204 prevention of, screening for, and treatment of behavioral health, mental health, and substance use
205 disorders, the service continues to be a covered service until the Public Employees Insurance
206 Agency notifies the covered person of the determination of the claim.

207 (h) Unless denied for nonpayment of premium, a denial of reimbursement for services for
208 the prevention of, screening for, or treatment of behavioral health, mental health, and substance
209 use disorders by the Public Employees Insurance Agency shall include the following language:

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

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

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

218 (i) On or after June 1, 2021, and annually thereafter, the Public Employees Insurance
219 Agency shall submit a written report to the Joint Committee on Government and Finance that
220 contains the following information regarding plans offered pursuant to this section:

221 (1) Data that demonstrates parity compliance for adverse determination regarding claims
222 for behavioral health, mental health, or substance use disorder services and includes the total
223 number of adverse determinations for such claims;

224 (2) A description of the process used to develop and select:

225 (A) The medical necessity criteria used in determining benefits for behavioral health,
226 mental health, and substance use disorders; and

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

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

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

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

242 (A) Identify factors used to determine whether a nonquantitative treatment limitation will
243 apply to a benefit, including factors that were considered but rejected;

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

246 (C) Provide the comparative analyses, including the results of the analyses, performed to
247 determine that the processes and strategies used to design each nonquantitative treatment
248 limitation, as written, and the written processes and strategies used to apply each nonquantitative
249 treatment limitation for benefits for behavioral health, mental health, and substance use disorders
250 are comparable to, and are applied no more stringently than, the processes and strategies used to

251 design and apply each nonquantitative treatment limitation, as written, and the written processes
252 and strategies used to apply each nonquantitative treatment limitation for medical and surgical
253 benefits;

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

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

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

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

271 ~~(k) This section is effective for policies, contracts, plans or agreements, beginning on or~~
272 ~~after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject~~
273 ~~to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on~~
274 ~~or after the effective date of this section. The Public Employees Insurance Agency shall maintain at~~
275 ~~a minimum a 20 percent cost share for instate benefits, when applicable, and a minimum of 30~~
276 ~~percent cost share for out of state benefits, when applicable.~~

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

1 (a) The following terms are defined:

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

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

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

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

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

21 (6) "Telehealth services" means the use of synchronous or asynchronous
22 telecommunications technology or audio-only telephone calls by a health care practitioner to
23 provide health care services, including, but not limited to, assessment, diagnosis, consultation,
24 treatment, and monitoring of a patient; transfer of medical data; patient and professional health-

25 ~~related education; public health services; and health administration. The term does not include e-~~
26 ~~mail messages, or facsimile transmissions.~~

27 (7) ~~"Virtual telehealth" means a new patient or follow-up patient for acute care that does not~~
28 ~~require chronic management or scheduled medications.~~

29 (b) ~~(a)~~ After July 1, 2020 The plan shall provide coverage of health care services provided
30 through telehealth services if those same services are covered through face-to-face consultation
31 by the policy.

32 (c) ~~(b)~~ After July 1, 2020 The plan may not exclude a service for coverage solely because
33 the service is provided through telehealth services.

34 (d) ~~(c)~~ The plan ~~which issues, renews, amends, or adjusts a plan, policy, contract, or~~
35 ~~agreement on or after July 1, 2021~~ shall provide reimbursement for a telehealth service at a rate
36 negotiated between the provider and the insurance company for virtual telehealth encounters. The
37 plan ~~which issues, renews, amends, or adjusts a plan, policy, contract, or agreement on or after~~
38 ~~July 1, 2021~~ shall provide reimbursement for a telehealth service for an established patient, or
39 care rendered on a consulting basis to a patient located in an acute care facility, whether inpatient
40 or outpatient, on the same basis and at the same rate under a contract, plan, agreement, or policy
41 as if the service is provided through an in-person encounter rather than provided via telehealth.

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

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

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

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

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

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

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

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

20 (b) The plan may not:

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

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

26 ~~(c) Nothing in this section shall be construed to prevent a health benefit plan policy or a~~
27 ~~health insurer offering health insurance coverage from negotiating the level and type of~~
28 ~~reimbursement with a provider for care provided in accordance with this section.~~

29 ~~(d) The provisions of this section shall be included under any policy, contract or plan~~
30 ~~delivered _____ after _____ July _____ 1, _____ 2002~~

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

1 (a) ~~A policy plan, or contract that is issued or renewed on or after July 1, 2020~~ shall provide
2 coverage for prescription insulin drugs pursuant to this section.

3 ~~(b) For the purposes of this subdivision, "prescription insulin drug" means a prescription~~
4 ~~drug that contains insulin and is used to treat diabetes, and includes at least one type of insulin in~~
5 ~~all of the following categories:~~

- 6 ~~(1) Rapid-acting;~~
- 7 ~~(2) Short-acting;~~
- 8 ~~(3) Intermediate-acting;~~
- 9 ~~(4) Long-acting;~~
- 10 ~~(5) Pre-mixed insulin products;~~
- 11 ~~(6) Pre-mixed insulin/GLP-1 RA products; and~~
- 12 ~~(7) Concentrated human regular insulin~~

13 ~~(c)~~ (b) Cost sharing for a 30-day supply of a covered prescription insulin drug shall not
14 exceed \$100 for a 30-day supply of a covered prescription insulin, regardless of the quantity or
15 type of prescription insulin used to fill the covered person's prescription needs.

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

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

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

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

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

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

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

1 The insurance plans provided for in this article shall be designed by the Public Employees

2 Insurance Agency:

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

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

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

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

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

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

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

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

28 (9) To provide health and wellness programs and resources impacting various components
29 of wellness. PEIA may explore, review, evaluate, and offer a variety of wellness programming and
30 resources to meet the needs of its members. These programs are voluntary for participants and
31 are separate and distinct from any medical benefit and ~~activities which will include, but not be~~
32 ~~limited to, benefit plan incentives to discourage tobacco, alcohol and chemical abuse and an~~
33 ~~educational program to encourage proper diet and exercise. In establishing "wellness" programs,~~
34 ~~the division of vocational rehabilitation shall cooperate with the Public Employees Insurance~~
35 ~~Agency in establishing statewide wellness programs. The director of the Public Employees~~
36 ~~Insurance Agency shall contract with county boards of education for the use of facilities,~~
37 ~~equipment or any service related to that purpose. Boards of education may charge only the cost of~~
38 ~~janitorial service and increased utilities for the use of the gymnasium and related equipment. The~~
39 ~~cost of the exercise program shall be paid by county boards of education, the Public Employees~~
40 ~~Insurance Agency, or participating employees, their spouses or dependents. All exercise~~
41 ~~programs shall be made available to all employees, their spouses or dependents and shall not be~~
42 ~~limited to employees of county boards of education;~~

43 (10) To provide a program, to be administered by the director, for a patient audit plan with
44 reimbursement up to a maximum of \$1,000 annually to employees for discovery of health care
45 provider or hospital overcharges when the affected employee brings the overcharge to the
46 attention of the plan. The hospital or health care provider shall certify to the director that it has
47 provided, prior to or simultaneously with the submission of the statement of charges for payments,
48 an itemized statement of the charges to the employee participant for which payment is requested
49 of the plan;

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

53 (12)(a) (A) To provide coverage for emergency services under offered plans. For the

54 purposes of this subsection, "emergency services" means services provided in or by a hospital
55 emergency facility, an ambulance providing related services under the provisions of §16-4C-1 *et*
56 *seq.* of this code, or the private office of a dentist to evaluate and treat a medical condition
57 manifesting itself by the sudden, and at the time, unexpected onset of symptoms that require
58 immediate medical attention and for which failure to provide medical attention would result in
59 serious impairment to bodily function, serious dysfunction to any bodily organ or part, or would
60 place the person's health in jeopardy.

61 ~~(b) (B) From July 1, 1998,~~ Plans shall provide coverage for emergency services, including
62 any pre-hospital services, to the extent necessary to screen and stabilize the covered person. The
63 plans shall reimburse, less any applicable copayments, deductibles, or coinsurance for
64 emergency services rendered and related to the condition for which the covered person
65 presented. Prior authorization of coverage shall not be required for the screening services if a
66 prudent layperson acting reasonably would have believed that an emergency medical condition
67 existed. Prior authorization of coverage shall not be required for stabilization if an emergency
68 medical condition exists. In the event that prior authorization was obtained, the authorization may
69 not be retracted after the services have been provided except when the authorization was based
70 on a material misrepresentation about the medical condition by the provider of the services or the
71 insured person. The provider of the emergency services and the plan representative shall make a
72 good faith effort to communicate with each other in a timely fashion to expedite post-evaluation or
73 post-stabilization services. Payment of claims for emergency services shall be based on the
74 retrospective review of the presenting history and symptoms of the covered person.

75 ~~(c) (C)~~ For purposes of this subdivision:

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

78 ~~(B)~~ "Prudent layperson" means a person who is without medical training and who draws on
79 his or her practical experience when making a decision regarding whether an emergency medical

80 condition exists for which emergency treatment should be sought;

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

86 (D) "Stabilize" means with respect to an emergency medical condition, to provide medical
87 treatment of the condition necessary to assure, with reasonable medical probability that no
88 medical deterioration of the condition is likely to result from or occur during the transfer of the
89 individual from a facility: *Provided*, That this provision may not be construed to prohibit, limit, or
90 otherwise delay the transportation required for a higher level of care than that possible at the
91 treating facility;

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

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

**§5-16-9. Authorization to execute contracts. ~~for group hospital and surgical insurance,~~
~~group major medical insurance, group prescription drug insurance, group life and~~
~~accidental death insurance, and other accidental death insurance; mandated~~
~~benefits; limitations; awarding of contracts; reinsurance; certificates for covered~~
~~employees; discontinuance of contracts~~**

1 (a) The director is given exclusive authorization to execute such contract or contracts as
2 are necessary to carry out the provisions of this article. and to provide the plan or plans of group
3 hospital and surgical insurance coverage, group major medical insurance coverage, group
4 prescription drug insurance coverage, and group life and accidental death insurance coverage
5 selected in accordance with the provisions of this article, such contract or contracts to be executed
6 with one or more agencies, corporations, insurance companies, or service organizations licensed
7 to sell group hospital and surgical insurance, group major medical insurance, group prescription
8 drug insurance and group life and accidental death insurance in this state.

9 (b) ~~The group hospital or surgical insurance coverage and group major medical insurance~~
10 ~~coverage herein provided shall include coverages and benefits for x-ray and laboratory services in~~
11 ~~connection with mammogram and pap smears when performed for cancer screening or diagnostic~~
12 ~~services and annual checkups for prostate cancer in men age 50 and over. Such benefits shall~~
13 ~~include, but not be limited to, the following:~~

14 (1) ~~Mammograms when medically appropriate and consistent with the current guidelines~~
15 ~~from the United States Preventive Services Task Force;~~

16 (2) ~~A pap smear, either conventional or liquid-based cytology, whichever is medically~~
17 ~~appropriate and consistent with the current guidelines from the United States Preventive Services~~
18 ~~Task Force or The American College of Obstetricians and Gynecologists, for women age 18 and~~
19 ~~over;~~

20 (3) ~~A test for the human papilloma virus (HPV) for women age 18 or over, when medically~~
21 ~~appropriate and consistent with the current guidelines from either the United States Preventive~~
22 ~~Services Task Force or the American College of Obstetricians and Gynecologists for women age~~
23 ~~18 and over;~~

24 (4) ~~A checkup for prostate cancer annually for men age 50 or over; and~~

25 (5) ~~Annual screening for kidney disease as determined to be medically necessary by a~~
26 ~~physician using any combination of blood pressure testing, urine albumin or urine protein testing,~~

27 and serum creatinine testing as recommended by the National Kidney Foundation.

28 ~~(6) Coverage for general anesthesia for dental procedures and associated outpatient~~
29 ~~hospital or ambulatory facility charges provided by appropriately licensed healthcare individuals in~~
30 ~~conjunction with dental care if the covered person is:~~

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

36 ~~(B) A child who is 12 years of age or younger with documented phobias, or with~~
37 ~~documented mental illness, and with dental needs of such magnitude that treatment should not be~~
38 ~~delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of~~
39 ~~teeth or other increased oral or dental morbidity and for whom a successful result cannot be~~
40 ~~expected from dental care provided under local anesthesia because of such condition and for~~
41 ~~whom a superior result can be expected from dental care provided under general anesthesia.~~

42 ~~(7) (A) A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and~~
43 ~~that is subject to this section, shall provide coverage, through the age of 20, for amino acid-based~~
44 ~~formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients~~
45 ~~caused by disorders affecting the absorptive surface, function, length, and motility of the~~
46 ~~gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder~~
47 ~~by a physician licensed to practice in this state pursuant to either §30-3-1 et seq. or §30-14-1 et~~
48 ~~seq. of this code:~~

49 ~~(i) Immunoglobulin E and Nonimmunoglobulin E-mediated allergies to multiple food~~
50 ~~proteins;~~

51 ~~(ii) Severe food protein-induced enterocolitis syndrome;~~

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

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

55 ~~(B) The coverage required by §5-16-9(b)(7)(A) of this code shall include medical foods for~~
56 ~~home use for which a physician has issued a prescription and has declared them to be medically~~
57 ~~necessary, regardless of methodology of delivery.~~

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

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

64 ~~(c) The group life and accidental death insurance herein provided shall be in the amount of~~
65 ~~\$10,000 for every employee. The amount of the group life and accidental death insurance to which~~
66 ~~an employee would otherwise be entitled shall be reduced to \$5,000 upon such employee~~
67 ~~attaining age 65.~~

68 ~~(d) All of the insurance coverage to be provided for under this article may be included in~~
69 ~~one or more similar contracts issued by the same or different carriers~~

70 ~~(e) (b) The provisions of §5A-3-1 *et seq.* of this code, relating to the Division of Purchasing~~
71 ~~of the Department of Finance and Administration, shall not apply to any contracts for any~~
72 ~~insurance coverage or professional services authorized to be executed under the provisions of~~
73 ~~this article. Before entering into any contract for any insurance coverage, as authorized in this~~
74 ~~article, the director shall invite competent bids from all qualified and licensed insurance companies~~
75 ~~or carriers, who that may wish to offer plans for the insurance coverage desired. *Provided,* That~~
76 ~~The director shall negotiate and contract directly with health care providers and other entities,~~
77 ~~organizations, and vendors in order to secure competitive premiums, prices, and other financial~~
78 ~~advantages. The director shall deal directly with insurers or health care providers and other~~

79 entities, organizations, and vendors in presenting specifications and receiving quotations for bid
80 purposes. No commission or finder's fee, or any combination thereof, shall be paid to any
81 individual or agent; ~~but: Provided, That~~ this shall not preclude an underwriting insurance company
82 or companies, at their own expense, from appointing a licensed resident agent within this state to
83 service the companies' contracts awarded under the provisions of this article. Commissions
84 reasonably related to actual service rendered for the agent or agents may be paid by the
85 underwriting company or companies. ~~Provided, however, That~~ In no event shall payment be made
86 to any agent or agents when no actual services are rendered or performed. The director shall
87 award the contract or contracts on a competitive basis. In awarding the contract or contracts the
88 director shall take into account the experience of the offering agency, corporation, insurance
89 company, or service organization in the group hospital and surgical insurance field, group major
90 medical insurance field, group prescription drug field, and group life and accidental death
91 insurance field, and its facilities for the handling of claims. In evaluating these factors, the director
92 may employ the services of impartial, professional insurance analysts or actuaries, or both. Any
93 contract executed by the director with a selected carrier shall be a contract to govern all eligible
94 employees subject to the provisions of this article. Nothing contained in this article shall prohibit
95 any insurance carrier from soliciting employees covered hereunder to purchase additional hospital
96 and surgical, major medical, or life and accidental death insurance coverage.

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

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

105 ~~(h)~~ (e) The director may at the end of any contract period discontinue any contract or
106 contracts it has executed with any carrier and replace the same with a contract or contracts with
107 any other carrier or carriers meeting the requirements of this article.

108 ~~(i) The director shall provide by contract or contracts entered into under the provisions of~~
109 ~~this article the cost for coverage of children's immunization services from birth through age 16~~
110 ~~years to provide immunization against the following illnesses: Diphtheria, polio, mumps, measles,~~
111 ~~rubella, tetanus, hepatitis-b, hemophilia influenzae b, and whooping cough. Additional~~
112 ~~immunizations may be required by the Commissioner of the Bureau for Public Health for public~~
113 ~~health purposes. Any contract entered into to cover these services shall require that all costs~~
114 ~~associated with immunization, including the cost of the vaccine, if incurred by the healthcare~~
115 ~~provider, and all costs of vaccine administration be exempt from any deductible, per visit charge~~
116 ~~and/or copayment provisions which may be in force in these policies or contracts. This section~~
117 ~~does not require that other healthcare services provided at the time of immunization be exempt~~
118 ~~from any deductible and/or copayment provisions~~

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

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

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

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

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

- 131 (A) The cost of drug reimbursement;
- 132 (B) Dispensing fees;
- 133 (C) Copayments; and
- 134 (D) The amount charged to the agency for each claim by the pharmacy benefit manager.

135 In the event there is a difference between the amount for any pharmacy claim paid to the
136 pharmacy provider and the amount reimbursed to the agency, the pharmacy benefit manager shall
137 report an itemization of all administrative fees, rebates, or processing charges associated with the
138 claim. All data and information provided by the pharmacy benefit manager shall be kept secure,
139 and notwithstanding any other provision of this code to the contrary, the agency shall maintain the
140 confidentiality of the proprietary information and not share or disclose the proprietary information
141 contained in the report or data collected with persons outside the agency. All data and information
142 provided by the pharmacy benefit manager shall be considered proprietary and confidential and
143 exempt from disclosure under the West Virginia Freedom of Information Act pursuant to §29B-1-
144 4(a)(1) of this code. Only those agency employees involved in collecting, securing, and analyzing
145 the data for the purpose of preparing the report provided for herein shall have access to the
146 proprietary data. The director shall provide a quarterly report to ~~the Joint Committee on~~
147 ~~Government and Finance~~ and the Joint Committee on Health detailing the information required by
148 this section, including any difference or spread between the overall amount paid by pharmacy
149 benefit managers to the pharmacy providers and the overall amount charged to the agency for
150 each claim by the pharmacy benefit manager. To the extent necessary, the director shall use
151 aggregated, nonproprietary data only: *Provided*, That the director must provide a clear and
152 concise summary of the total amounts charged to the agency and reimbursed to pharmacy
153 providers on a quarterly basis.

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

157 (h) The Public Employees Insurance Agency shall use a nationally accredited network to
158 provide care to its members out of state.

§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.

1 ~~Any contract or contracts entered into hereunder may provide for group hospital and~~
2 ~~surgical, group major medical, group prescription drug and group life and accidental death~~
3 ~~insurance~~ A plan may provide for retired employees and their spouses and dependents as defined
4 by rules and regulations of the Public Employees Insurance Agency, and on such terms as the
5 director may deem appropriate.

6 In the event the Public Employees Insurance Agency provides the above benefits for
7 retired employees, their spouses, and dependents, the Public Employees Insurance Agency shall
8 adopt rules and regulations prescribing the conditions under which retired employees may elect to
9 participate in or withdraw from the plan or plans. ~~Any contract or contracts herein~~ plan provided for
10 shall be secondary to any ~~hospital, surgical, major medical, prescription drug or other health~~
11 insurance plan administered by the United States Department of Health and Human Services to
12 which the retired employee, spouse, or dependent may be eligible under any law or regulation of
13 the United States. If an employee eligible to participate in the Public Employees Insurance Agency
14 plans is also eligible to participate in the state Medicaid program, and chooses to do so, then the
15 Public Employees Insurance Agency may transfer to the Medicaid program funds to pay the
16 required state share of such employee's participation in Medicaid except that the amount
17 transferred may not exceed the amount that would be allocated by the agency to subsidize the
18 cost of coverage for the retired employee if he or she were enrolled in the Public Employees
19 Insurance Agency's plans.

§5-16-11. To whom benefits paid.

1 ~~Any benefits payable under any group hospital and surgical, group major medical and~~

2 ~~group prescription drug plan or plans~~ a plan may be paid either directly to the attending physician
3 medical provider, hospital, medical group, or other person, firm, association, or corporation
4 furnishing the service upon which the claim is based, or to the insured upon presentation of valid
5 bills for such service, subject to such provisions designed to facilitate payments as may be made
6 by _____ the _____ director.

**§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.**

1 (a) ~~Cost sharing.~~— The director shall provide under any contract or contracts entered into
2 under the provisions of this article that the costs of any group hospital and surgical insurance,
3 group major medical insurance, group prescription drug insurance, group life and accidental death
4 insurance benefit plan or plans that shall be paid by the employer and employee.

5 (b) ~~Spouse and dependent coverage.~~— Each (1) An employee is entitled to have his or her
6 spouse and dependents included in any ~~group hospital and surgical insurance, group major~~
7 ~~medical insurance or group prescription drug insurance coverage~~ plan to which the employee is
8 entitled to participate. ~~Provided, That~~

9 (2) The spouse and dependent coverage is limited to excess or secondary coverage for
10 each spouse and dependent who has primary coverage from any other source. If an employee's
11 spouse has health insurance available through an employer not defined by §5-16-2 of this code,
12 then the employer may not cover any portion of premiums for the employee's spouse coverage:
13 Provided, That the prohibition does not apply to spouses of retired employees: Provided, however,
14 That an employee may add his or her spouse to his or her coverage by paying the cost of the
15 actuarial value of the plan: Provided further, That for spousal premium coverage by the employer,

16 this subdivision does not apply to voluntary employers pursuant to section §5-16-22 of this code.

17 ~~For purposes of this section, the term "primary coverage" means individual or group~~
18 ~~hospital and surgical insurance coverage or individual or group major medical insurance coverage~~
19 ~~or group prescription drug coverage in which the spouse or dependent is the named insured or~~
20 ~~certificate holder. For the purposes of this section, "dependent" includes an eligible employee's~~
21 ~~unmarried child or stepchild under the age of 25 if that child or stepchild meets the definition of a~~
22 ~~"qualifying child" or a "qualifying relative" in Section 152 of the Internal Revenue Code. The director~~
23 ~~may require proof regarding spouse and dependent primary coverage and shall adopt rules~~
24 ~~governing the nature, discontinuance, and resumption of any employee's coverage for his or her~~
25 ~~spouse and dependents.~~

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

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

42 before reaching the age of ~~sixty-five~~ 65, or when a participating employee voluntarily retires as
43 provided by law, that employee's accrued annual leave and sick leave, if any, shall be credited
44 toward an extension of the insurance coverage provided by this article, according to the following
45 formulae: The insurance coverage for a retired employee shall continue one additional month for
46 every two days of annual leave or sick leave, or both, which the employee had accrued as of the
47 effective date of his or her retirement. For a retired employee, his or her spouse and dependents,
48 the insurance coverage shall continue one additional month for every three days of annual leave
49 or sick leave, or both, which the employee had accrued as of the effective date of his or her
50 retirement.

51 ~~(e) Conversion of accrued annual and sick leave for extended insurance coverage upon~~
52 ~~retirement for employees who elected to participate in the plan after June, 1988. --~~

53 Notwithstanding subsection (d) of this section, and except as otherwise provided in subsections
54 (g) and (l) of this section, when an employee participating in the plan who elected to participate in
55 the plan on and after July 1, 1988, is compelled or required by law to retire before reaching the age
56 of 65, or when the participating employee voluntarily retires as provided by law, that employee's
57 annual leave or sick leave, if any, shall be credited toward one half of the premium cost of the
58 insurance provided by this article, for periods and scope of coverage determined according to the
59 following formulae: (1) One additional month of single retiree coverage for every two days of
60 annual leave or sick leave, or both, which the employee had accrued as of the effective date of his
61 or her retirement; or (2) one additional month of coverage for a retiree, his or her spouse, and
62 dependents for every three days of annual leave or sick leave, or both, which the employee had
63 accrued as of the effective date of his or her retirement. The remaining premium cost shall be
64 borne by the retired employee if he or she elects the coverage. For purposes of this subsection, an
65 employee who has been a participant under spouse or dependent coverage and who reenters the
66 plan within 12 months after termination of his or her prior coverage shall be considered to have
67 elected to participate in the plan as of the date of commencement of the prior coverage. For

68 purposes of this subsection, an employee shall not be considered a new employee after returning
69 from extended authorized leave on or after July 1, 1988.

70 ~~(f) Increased retirement benefits for retired employees with accrued annual and sick leave.~~

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

82 ~~(g) Conversion of accrued annual and sick leave for extended insurance coverage upon~~

83 ~~retirement for certain higher education employees.~~ Except as otherwise provided in subsection (l)
84 of this section, when an employee, who is a higher education full-time faculty member employed
85 on an annual contract basis other than for 12 months, is compelled or required by law to retire
86 before reaching the age of 65, or when such a participating employee voluntarily retires as
87 provided by law, that employee's insurance coverage, as provided by this article, shall be
88 extended according to the following formulae: The insurance coverage for a retired higher
89 education full-time faculty member, formerly employed on an annual contract basis other than for
90 12 months, shall continue beyond the effective date of his or her retirement one additional year for
91 each three and one-third years of teaching service, as determined by uniform guidelines
92 established by the University of West Virginia Board of Trustees and the Board of Directors of the
93 State College System, for individual coverage, or one additional year for each five years of

94 teaching service for family coverage.

95 ~~(h) Any employee who retired prior to April 21, 1972, and who also otherwise meets the~~
96 ~~conditions of the "retired employee" definition in section two of this article, shall be eligible for~~
97 ~~insurance coverage under the same terms and provisions of this article. The retired employee's~~
98 ~~premium contribution for any such coverage shall be established by the finance board.~~

99 ~~(i) (h) *Retiree participation.*— All retirees under the provisions of this article, including those~~
100 ~~defined in section two of this article; those retiring prior to April 21, 1972; and those hereafter~~
101 ~~retiring~~ All retired employees are eligible to obtain health insurance coverage. The retired
102 employee's premium contribution for the coverage shall be established by the finance board.

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

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

117 ~~(l) *Participation of certain former employees.*— An employee, eligible for coverage under~~
118 ~~the provisions of this article who has twenty years of service with any agency or entity participating~~
119 ~~in the public employees insurance program or who has been covered by the public employees~~

120 insurance program for twenty years may, upon leaving employment with a participating agency or
121 entity, continue to be covered by the program if the employee pays one hundred five percent of the
122 cost of retiree coverage: *Provided*, That the employee shall elect to continue coverage under this
123 subsection within two years of the date the employment with a participating agency or entity is
124 terminated.

125 ~~(m) (k) Prohibition on conversion of accrued annual and sick leave for extended coverage~~
126 ~~upon retirement for new employees who elect to participate in the plan after June, 2001.~~— Any
127 employee hired on or after July 1, 2001, who elects to participate in the plan may not apply accrued
128 annual or sick leave toward the cost of premiums for extended insurance coverage upon his or her
129 retirement. This prohibition does not apply to the conversion of accrued annual or sick leave for
130 increased retirement benefits, as authorized by this section: *Provided*, That any person who has
131 participated in the plan prior to July 1, 2001, is not a new employee for purposes of this subsection
132 if he or she becomes reemployed with an employer participating in the plan within two years
133 following his or her separation from employment and he or she elects to participate in the plan
134 upon his or her reemployment.

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

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

1 The director shall develop, implement and have in place by December 31, 1990,
2 deductible and employee premium programs which qualify for favorable federal income tax
3 treatment under section 125 of the Internal Revenue Code.

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

1 (a) ~~On and after July 1, 1989~~ The director shall make available to participants in the public
2 employees insurance system:

- 3 (1) A dental insurance plan;
- 4 (2) An optical insurance plan;
- 5 (3) A disability insurance plan;
- 6 (4) A prepaid retirement insurance plan; and
- 7 (5) An audiology and hearing-aid services insurance plan.

8 **(b)** Public employees insurance participants may elect to participate in any one of these
9 plans separately or in combination. All actuarial and administrative costs of each plan shall be
10 totally borne by the premium payments of the participants or local governing bodies electing to
11 participate in that plan. The director is authorized to employ such administrative practices and
12 procedures with respect to these optional plans as are authorized for the administration of other
13 plans under this article. The director shall establish separate funds ~~(1) For deposit of dental~~
14 ~~insurance premiums and payment of dental insurance claims; (2) for deposit of optical insurance~~
15 ~~premium payments and payment of optical insurance claims; (3) for deposit of disability insurance~~
16 ~~premium payments and payment of disability insurance claims; and (4) for deposit of audiology~~
17 ~~and hearing-aid service insurance premiums and payment of audiology and hearing-aid insurance~~
18 ~~claims~~ for each of the above listed plans. Such The funds shall not be supplemented by nor be
19 used to supplement any other funds.

20 ~~(b) The Finance Board shall study the feasibility of an oral health benefit for children of~~
21 ~~participants~~

§5-16-16. Preferred provider plan.

1 The director shall ~~on or before April 1, 1988,~~ or as soon as practicable establish a preferred
2 provider system for the delivery of health care to plan participants by all health care providers,
3 which may include, but not be limited to, medical doctors, chiropractors, physicians, osteopathic
4 physicians, surgeons, hospitals, clinics, nursing homes, pharmacies, and pharmaceutical

5 companies.

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

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

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

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

20 shall pay for covered employees during the following fiscal year.

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

25 (d) The contribution of the other employers (~~namely: A county, city, or town~~) that are
26 counties, cities, or towns in the state; any separate corporation or instrumentality established by
27 one or more counties, cities, or towns, as permitted by law; any corporation or instrumentality
28 supported in most part by counties, cities or towns; any public corporation charged by law with the
29 performance of a governmental function and whose jurisdiction is coextensive with one or more
30 counties, cities, or towns; any comprehensive community mental health center or comprehensive
31 mental ~~retardation~~ health facility established, operated, or licensed by the Secretary of the
32 Department of Health and Human Resources pursuant to ~~section one, article two-a, chapter~~
33 ~~twenty-seven~~ §27-2A-1 et seq. of this code, and which is supported in part by state, county, or
34 municipal funds; and a combined city-county health department created pursuant to §16-2-1 *et*
35 *seq.* of this code for their employees shall be the percentage of the cost of the employees'
36 insurance package as the employers determine reasonable and proper under their own particular
37 circumstances.

38 (e) The employee's proportionate share of the premium or cost shall be withheld or
39 deducted by the employer from the employee's salary or wages as and when paid and the sums
40 shall be forwarded to the director with any supporting data as the director may require.

41 (f) All moneys received by the Public Employees Insurance Agency shall be deposited in a
42 special fund or funds as are necessary in the State Treasury and the Treasurer ~~of the state~~ is
43 custodian of the fund or funds and shall administer the fund or funds in accordance with the
44 provisions of this article or as the director may from time to time direct. The Treasurer shall pay all
45 warrants issued by the State Auditor against the fund or funds as the director may direct in

46 accordance with the provisions of this article. All funds received by the agency, ~~including, but not~~
47 ~~limited to, basic insurance premiums, administrative expenses and optional life insurance~~
48 ~~premiums~~ shall be deposited, as determined by the director, in any of the investment pools with the
49 West Virginia Investment Management Board, ~~including, but not limited to, the equity and fixed~~
50 ~~income pools~~ with the interest income or other earnings a proper credit to all such funds for the
51 benefit of the Public Employees Insurance Agency.

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

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

1 ~~Notwithstanding the definition of the term "employee" contained in section two of this~~
2 ~~article and~~ Notwithstanding any other provision of this article to the contrary, members of the
3 Legislature may participate in and be covered by any insurance plan or plans authorized
4 hereunder for state officers and employees, except that all members of the Legislature who elect
5 to participate in or to be covered by any such plan or plans shall pay their proportionate individual
6 share of the full cost for all group coverage on themselves, ~~and~~ their spouses, and dependents, so
7 that there will be no cost to the state for the coverage of any such members, spouses, and
8 dependents.

§5-16-25. Reserve fund.

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

[Repealed.]

§5-16-30. PEIA solvency.

1 The Public Employees Insurance Agency shall return to a level of 80 percent for the
2 employer and 20 percent for employees during fiscal year 2024.

§5-16-31. PEIA actuarial study.

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

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

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