

# **WEST VIRGINIA LEGISLATURE**

## **2025 REGULAR SESSION**

**Introduced**

### **Senate Bill 426**

By Senator Taylor

[Introduced February 13, 2025; referred  
to the Committee on Banking and Insurance; and  
then to the Committee on Finance]

1 A BILL to amend and reenact §5-16-1, §5-16-2, §5-16-3, §5-16-4, §5-16-5, §5-16-7, §5-16-7a, §5-  
2 16-7c, §5-16-7d, §5-16-8, §5-16-9, §5-16-10, §5-16-11, §5-16-12, §5-16-12a, §5-16-13,  
3 §5-16-15, §5-16-16, §5-16-17, §5-16-18, and §5-16-24 of the Code of West Virginia, 1931,  
4 as amended; to amend the code by adding a new article, designated §5-16A-1, §5-16A-2,  
5 §5-16A-3, §5-16A-4, §5-16A-5, §5-16A-6, §5-16A-7, §5-16A-8, §5-16A-9, §5-16A-10, §5-  
6 16A-11, §5-16A-12, §5-16A-13, §5-16A-14, §5-16A-15, §5-16A-16, §5-16A-17, §5-16A-  
7 18, §5-16A-19, and §5-16A-20; and to repeal §5-16-7e, relating generally to the Public  
8 Employees Insurance Agency; providing for dissolution of the Public Employees Insurance  
9 Agency; converting state agency to employer-owned mutual insurance company; setting  
10 forth a short title; defining terms; clarifying the duties of the director; providing for private  
11 carriers to insure public employees; providing for employees of the agency to be exempt  
12 from provisions of civil service coverage; providing for personnel provisions for employees  
13 laid off in first year of operation; providing for retraining benefits for laid-off employees;  
14 providing for transfer of certain Public Employees Insurance Agency functions, rights,  
15 responsibilities, employees and assets to the Insurance Commissioner and the Public  
16 Employees Insurance Council; providing certain civil remedies to commission, mutual  
17 company and private carriers; providing for transfer of authority over certain funds to the  
18 Insurance Commissioner; providing for capital and surplus requirements of employers'  
19 mutual insurance company; providing for election of a board of directors of employers'  
20 mutual insurance company; providing for governance and organization of the new mutual  
21 insurance company; providing for establishment of claims index to assist insurers;  
22 providing for establishment and administration of certain funds and accounts in the State  
23 Treasury; providing for adverse risk assignment plan; providing, upon meeting of certain  
24 criteria, for issuance of proclamation by the Governor; providing for preferential placement  
25 of any employee laid off after transfer of functions; providing certain retraining and other  
26 benefits; providing for novation of policies to new employers mutual insurance company;

27 providing for requirements of a basic policy of public employees insurance; providing for  
28 setting of insurance rates; providing for collection of premiums; providing for transfer of  
29 rules to be applicable to the public employees insurance market; providing for transfer of  
30 certain assets to new mutual insurance company; providing for selection of finance board  
31 members by Governor; providing for a Public Employees Insurance Council; making  
32 technical corrections throughout; providing internal effective dates; providing for civil  
33 administrative and criminal penalties; and making conforming changes throughout.

*Be it enacted by the Legislature of West Virginia:*

## **ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.**

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

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

6 This article shall be referred to as the West Virginia Public Employees Insurance  
7 Privatization 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 ~~"Agency" or "PEIA" means the Public Employees Insurance Agency created by this article.~~

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

8 ~~"Autism spectrum disorder" means any pervasive developmental disorder, including~~

~~autistic disorder, Asperger's syndrome, Rett syndrome, childhood disintegrative disorder, or Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.~~

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

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

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

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

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

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

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

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

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

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

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

65 ~~"Employer" means the State of West Virginia, its boards, agencies, commissions,~~  
66 ~~departments, institutions, or spending units; a county board of education; a public charter school~~  
67 ~~established pursuant to §18-5G-1 et seq. of this code if the charter school includes in its charter~~  
68 ~~contract entered into pursuant to §18-5G-7 of this code a determination to participate in the Public~~  
69 ~~Employees Insurance Program; a county, city, or town in the state; any separate corporation or~~  
70 ~~instrumentality established by one or more counties, cities, or towns, as permitted by law; any~~  
71 ~~corporation or instrumentality supported in most part by counties, cities, or towns; any public~~  
72 ~~corporation charged by law with the performance of a governmental function and whose~~  
73 ~~jurisdiction is coextensive with one or more counties, cities, or towns; any comprehensive~~  
74 ~~community mental health center or intellectually and developmentally disabled facility established,~~  
75 ~~operated, or licensed by the Secretary of the Department of Health and Human Resources~~  
76 ~~pursuant to §27-2A-1 et seq. of this code and which is supported in part by state, county, or~~  
77 ~~municipal funds; a combined city-county health department created pursuant to §16-2-1 et seq. of~~  
78 ~~this code; and a corporation meeting the description set forth in §18B-12-3 of this code that is~~  
79 ~~employing a 21st Century Learner Fellow pursuant to §18A-3-11 of this code but the corporation is~~  
80 ~~not considered an employer with respect to any employee other than a 21st Century Learner~~  
81 ~~Fellow. Any matters of doubt as to who is an "employer" within the meaning of this article shall be~~  
82 ~~decided by the director. The term "employer" does not include within its meaning the National~~  
83 ~~Guard.~~

84 ~~"Established patient" means a patient who has received professional services, face-to-~~  
85 ~~face, from the physician, qualified health care professional, or another physician or qualified health~~  
86 ~~care professional of the exact same specialty and subspecialty who belongs to the same group~~

87 ~~practice, within the past three years.~~

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

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

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

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

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

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

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

110 ~~(1) Rapid-acting;~~

111 ~~(2) Short-acting;~~

112 ~~(3) Intermediate-acting;~~

~~(4) Long-acting;~~

~~(5) Pre-mixed insulin products;~~

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

~~(7) Concentrated human regular insulin.~~

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

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

~~"Retired employee" means an employee of the state who retired after April 29, 1971, and an employee of the Higher Education Policy Commission, the Council for Community and Technical College Education, a state institution of higher education, or a county board of education who retires on or after April 21, 1972, and all additional eligible employees who retire on or after the effective date of this article, meet the minimum eligibility requirements for their respective state retirement system, and whose last employer immediately prior to retirement under the state retirement system is a participating employer in the state retirement system and in the Public Employees Insurance Agency: *Provided*, That for the purposes of this article, the employees who are not covered by a state retirement system, but who are covered by a state-approved or state-contracted retirement program or a system approved by the director, shall, in the case of education employees, meet the minimum eligibility requirements of the State Teachers Retirement System, and in all other cases, meet the minimum eligibility requirements of the Public Employees Retirement System and may participate in the Public Employees Insurance Agency as retired employees upon terms as the director sets by rule as authorized in this article. Employers with~~



~~employees who are, or who are eligible to become, retired employees under this article shall be mandatory participants in the Retiree Health Benefit Trust Fund created pursuant to §5-16D-1 et seq. of this code. Nonstate employers may opt out of the West Virginia other post-employment benefits plan of the Retiree Health Benefit Trust Fund and elect to not provide benefits under the Public Employees Insurance Agency to retirees of the nonstate employer, but may do so only upon the written certification, under oath, of an authorized officer of the employer that the employer has no employees who are, or who are eligible to become, retired employees and that the employer will defend and hold harmless the Public Employees Insurance Agency from any claim by one of the employer's past, present, or future employees for eligibility to participate in the Public Employees Insurance Agency as a retired employee. As a matter of law, the Public Employees Insurance Agency shall not be liable in any respect to provide plan benefits to a retired employee of a nonstate employer which has opted out of the West Virginia other post-employment benefits plan of the Retiree Health Benefit Trust Fund pursuant to this section.~~

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

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

As used in this article:

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

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

measurement and functional analysis of the relationship between environment and behavior.

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

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

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

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

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

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

"Cooperative group" means a formal network of facilities that collaborate on research projects and have an established National Institute of Health (NIH)-approved peer review program operating within the group. A cooperative group includes:

(A) The national cancer institute clinical cooperative group;

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

(C) The AIDS clinical trial group; and

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

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

191 this article.

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

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

202 "Emergency services" means those services required to screen for or treat an emergency  
203 medical condition until the condition is stabilized, including prehospital care;

204 "Employee" means any person, including an elected officer, who works regularly full time in  
205 the service of the State of West Virginia and, for the purpose of this article only, the term  
206 "employee" also means any person, including an elected officer, who works regularly full time in  
207 the service of a county board of education; a county, city or town in the state; any separate  
208 corporation or instrumentality established by one or more counties, cities or towns, as permitted by  
209 law; any corporation or instrumentality supported in most part by counties, cities or towns; any  
210 public corporation charged by law with the performance of a governmental function and whose  
211 jurisdiction is coextensive with one or more counties, cities or towns; any comprehensive  
212 community mental health center or comprehensive mental retardation facility established,  
213 operated or licensed by the Secretary of Health and Human Resources pursuant to §27-2A-1 and  
214 which is supported in part by state, county or municipal funds; any person who works regularly full  
215 time in the service of the Higher Education Policy Commission, the West Virginia Council for  
216 Community and Technical College Education or a governing board, as defined in §18B-1-2; any

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

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

- (i) Participates in a job-sharing arrangement as defined in §18A-11;
- (ii) Has been designated, in writing, by all other participants in that job-sharing arrangement as the "employee" for purposes of this section; and
- (iii) Works at least one-third of the time required for a full-time employee.

"Employer" means the State of West Virginia, its boards, agencies, commissions,

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

"FDA" means the federal Food and Drug Administration.

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

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

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

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

"Multiple project assurance contract" means a contract between an institution and the

federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that shall be used by the institution to protect human subjects.

"NIH" means the National Institutes of Health.

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

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

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

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

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

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

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

(F) Adverse events during treatment are divided into those that reflect the natural history of the disease, or its progression, and those that are unique in the experimental treatment. Costs for the former are the responsibility of the payor as provided in §5-16-2, and costs for the later are the

responsibility of the sponsor. The sponsor shall hold harmless any payor for any losses and injuries sustained by any member as a result of his or her participation in the clinical trial.

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

"Plan", unless the context indicates otherwise, means the medical indemnity plan, the managed care plan option or the group life insurance plan offered by the agency.

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

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

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

"Retired employee" means an employee of the state who retired after April 29, 1971, and an employee of the Higher Education Policy Commission, the Council for Community and Technical College Education, a state institution of higher education or a county board of education who retires on or after April 21, 1972, and all additional eligible employees who retire on or after

the effective date of this article, meet the minimum eligibility requirements for their respective state retirement system and whose last employer immediately prior to retirement under the state retirement system is a participating employer in the state retirement system and in the Public Employees Insurance Agency: *Provided*, That for the purposes of this article, the employees who are not covered by a state retirement system, but who are covered by a state-approved or state-contracted retirement program or a system approved by the director, shall, in the case of education employees, meet the minimum eligibility requirements of the state Teachers Retirement System and in all other cases, meet the minimum eligibility requirements of the Public Employees Retirement System and may participate in the Public Employees Insurance Agency as retired employees upon terms as the director sets by rule as authorized in this article. Employers with employees who are, or who are eligible to become, retired employees under this article shall be mandatory participants in the Retiree Health Benefit Trust Fund created pursuant to §5-16D-1 *et seq.* Nonstate employers may opt out of the West Virginia other post-employment benefits plan of the Retiree Health Benefit Trust Fund and elect to not provide benefits under the Public Employees Insurance Agency to retirees of the nonstate employer, but may do so only upon the written certification, under oath, of an authorized officer of the employer that the employer has no employees who are, or who are eligible to become, retired employees and that the employer will defend and hold harmless the Public Employees Insurance Agency from any claim by one of the employer's past, present or future employees for eligibility to participate in the Public Employees Insurance Agency as a retired employee. As a matter of law, the Public Employees Insurance Agency may not be liable in any respect to provide plan benefits to a retired employee of a nonstate employer which has opted out of the West Virginia other post-employment benefits plan of the Retiree Health Benefit Trust Fund pursuant to this section.

"Stabilize" means with respect to an emergency medical condition, to provide medical treatment of the condition necessary to assure, with reasonable medical probability that no medical deterioration of the condition is likely to result from or occur during the transfer of the



individual from a facility: Provided, That this provision may not be construed to prohibit, limit or otherwise delay the transportation required for a higher level of care than that possible at the treating facility.

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

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

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

(c) The director is responsible for the administration and management of the Public Employees Insurance Agency as provided in this article and in connection with his or her responsibility may make all rules necessary to effectuate the provisions of this article. Nothing in §5-16-4 or §5-16-5 of this code limits the director's ability to manage on a day-to-day basis the group insurance plans required or authorized by this article, including, but not limited to, administrative contracting, studies, analyses and audits, eligibility determinations, utilization management provisions and incentives, provider negotiations, provider contracting and payment,

23 designation of covered and noncovered services, offering of additional coverage options or cost  
24 containment incentives, pursuit of coordination of benefits, and subrogation, or any other actions  
25 which would serve to implement the plan or plans designed by the finance board. The director is to  
26 function as a benefits management professional and should avoid political involvement in  
27 managing the affairs of the Public Employees Insurance Agency.

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

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

38 (1) Increasing generic fill rates;

39 (2) Managing specialty pharmacy costs;

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

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

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

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

48 (7) Evaluating the expenditures to reduce excessive use of emergency room visits,

imaging services, and other drivers of the agency's medical rate of inflation;

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

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

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

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

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

(f) Perform all of the duties set forth in §5-16A-1 et seq.

(g) Notwithstanding any provision of this code to the contrary, effective July 1, 2025, if the agency has not been terminated or otherwise discontinued, all employees of the agency are exempt and otherwise not under the jurisdiction of the provisions of the statutes and rules of the classified service set forth in §29A-6-1 et seq. and §29-6A-1 et seq., and §5-16A-1 et seq. and are afforded no protections, rights or access to procedures set forth in those provisions; instead, all agency employees are at-will employees unless that status is altered by an express, written employment contract executed on behalf of the agency and the employee. The agency and its employees also are exempt and otherwise not under the jurisdiction of the state personnel board,

75 the Department of Personnel, or any other successor agency and their statutes and rules.

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

1 (a) If the company created in §5-16A-1 et seq. is created and is operational, the The Public  
2 Employees Insurance Agency Finance Board ~~is continued~~ shall continue and consists of the  
3 Secretary of the Department of Administration or his or her designee, as a voting member, and 10  
4 members appointed by the Governor, with the advice and consent of the Senate, for terms of four  
5 years and each may serve until his or her successor is appointed and qualified. Members may be  
6 reappointed for successive terms. No more than six members, including the Secretary of the  
7 Department of Administration, may be of the same political party. ~~Members~~ Effective July 1, 2025,  
8 members of the board shall satisfy the qualification requirements provided for by subsection (b) of  
9 this section. The Governor shall make appointments necessary to satisfy the requirements of  
10 subsection (b) of this section to staggered terms as determined by the Governor.

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

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

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

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

23 (D) One member shall represent the interests of a participating political subdivision. The  
24 member shall have been employed by a political subdivision for a period of at least three years

25 prior to his or her appointment and shall remain an employee of a political subdivision for the  
26 duration of his or her appointment to remain eligible to serve on the board. The member may not  
27 be an elected official.

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

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

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

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

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

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

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

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

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

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

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

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

(d) Upon termination of the board and notwithstanding any provisions of this article to the contrary, the director is authorized to assess monthly employee premium contributions and to change the types and levels of costs to employees only in accordance with this subsection. Any assessments or changes in costs imposed pursuant to this subsection shall be implemented by legislative rule proposed by the director for promulgation pursuant to §29A-3-1 *et seq.* of this code. Any employee assessments or costs previously authorized by the finance board shall then remain in effect until amended by rule of the director promulgated pursuant to this subsection.

(e) If the company set forth in §5-16A-1 *et seq.* is created and operational then the current agency shall continue to exist through June 30, 2025, at which time all powers and duties to

75 enforce any rules adopted by the agency are transferred to the Insurance Commissioner or any  
76 other applicable state agency or division. If the company created in §5-16A-1 et seq. is not created  
77 or is not operational then the agency shall retain all powers and duties to enforce the rules adopted  
78 by the agency until such time as the company created in §5-16A-1 et seq. is created and is  
79 operational.

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

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

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

19 (c) All financial plans shall establish:

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

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

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

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

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

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

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

(2) The finance board shall prepare a proposed financial plan designed to generate revenues sufficient to meet all estimated program and administrative costs of the Public Employees Insurance Agency for the fiscal year. The proposed financial plan shall allow for no



45 more than 30 days of accounts payable to be carried over into the next fiscal year. Before final  
46 adoption of the proposed financial plan, the finance board shall request the actuary to review the  
47 plan and to render a written professional opinion stating whether the plan will generate sufficient  
48 revenues to meet all estimated program and administrative costs of the Public Employees  
49 Insurance Agency for the fiscal year. The actuary's report shall explain the basis of its opinion. If  
50 the actuary concludes that the proposed financial plan will not generate sufficient revenues to  
51 meet all anticipated costs, then the finance board shall make necessary modifications to the  
52 proposed plan to ensure that all actuarially determined financial requirements of the agency will be  
53 met.

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

57 (4) For each fiscal year, the Governor shall provide his or her estimate of total revenues to  
58 the finance board no later than October 15 of the preceding fiscal year: *Provided*, That for the  
59 prospective financial plans required by this section, the Governor shall estimate the revenues  
60 available for each fiscal year of the plans based on the estimated percentage of growth in general  
61 fund revenues: *Provided, however*, That the director and finance board may only use revenue  
62 estimates from the Governor as necessary to maintain an actuarially recommended reserve fund  
63 and to maintain premium cost-sharing percentages as required in this article: *Provided, further*,  
64 That the director and finance board may not incorporate revenue sources into the finance board  
65 plan beyond the premium cost-sharing percentages as required in this article. The director shall  
66 provide the number of covered lives for the current fiscal year and a five-year analysis of the costs  
67 for covering paid claims to the finance board no later than October 15 of the preceding year. The  
68 finance board shall submit its final approved financial plan after obtaining the necessary actuary's  
69 opinion, which opinion shall include, but not be limited to, the aggregate premium cost-sharing

percentages between employers and employees, including the amounts of any subsidization of retired employee benefits, at a level of 80 percent for the employer and 20 percent for employees, to the Governor and to the Legislature no later than January 1 preceding the fiscal year. The financial plan for a fiscal year becomes effective and shall be implemented by the director on July 1 of the fiscal year. In addition to each final approved financial plan required under this section, the finance board shall also simultaneously submit financial statements based on generally accepted accounting practices (GAAP) and the final approved plan restated on an accrual basis of accounting, which shall include allowances for incurred but not reported claims. The financial statements and the accrual-based financial plan restatement shall may not affect the approved financial plan.

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

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

(g) The prospective financial plans shall be based on the estimated revenues submitted in accordance §5-16-5(d)(4) of this code and shall include an average of the projected cost-sharing percentages of premiums and an average of the projected deductibles and copays for the various programs. Each plan year, the aggregate premium cost-sharing percentages between employers and employees, including the amounts of any subsidization of retired employee benefits, shall be at a level of 80 percent for the employer and 20 percent for employees, except for the employers provided in §5-16-18(d) of this code whose premium cost-sharing percentages shall be governed

95 by that subsection. After the submission of the initial prospective plan, the board may not increase  
96 costs to the participating employers or change the average of the premiums, deductibles, and  
97 copays for employees, except in the event of a true emergency. If the board invokes the  
98 emergency provisions, the cost shall be borne between the employers and employees in  
99 proportion to the cost-sharing ratio for that plan year. For purposes of this section, "emergency"  
100 means that the most recent projections demonstrate that plan expenses will exceed plan revenues  
101 by more than one percent in any plan year. The aggregate premium cost-sharing percentages  
102 between employers and employees, including the amounts of any subsidization of retired  
103 employee benefits, may be offset, in part, by a legislative appropriation for that purpose.

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

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

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

118 (k) Notwithstanding any provision of this code to the contrary on or after July 2025, the  
119 finance board shall develop a plan to allow the insurance plans authorized pursuant to this article

120 to be sold and compete on the open insurance market. These plans shall continue to be sold on  
121 the open insurance market until such time as the company created in §5-16A-1 *et seq.* is created.  
122 The finance board shall submit an annual report on the financial soundness of continuing to  
123 compete on the open insurance market to the Joint Committee on Government and Finance by  
124 December 31 each year starting with December 2025. Any insurance plans sold pursuant to the  
125 authority of this section are subject to oversight of the Insurance Commission.

126 (l) If the company created in §5-16A-1 *et seq.* is created and operational then the current  
127 agency shall continue to exist through June 30, 2025, at which time all powers and duties of to  
128 enforce rules are transferred to the Insurance Commissioner or any other applicable state agency  
129 or division. If the company created in §5-16A-1 *et seq.* is not created or is not operational then the  
130 agency shall retain all powers and duties to enforce the rules adopted by the agency until such  
131 time as the company created in §5-16A-1 *et seq.* is created and is operational.

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

1 (a) The agency or the company created pursuant to §5-16A-1 *et seq.* shall establish plans  
2 for those employees herein made eligible and establish and promulgate rules for the  
3 administration of these plans subject to the limitations contained in this article. If the company  
4 created in §5-16A-1 *et seq.* is created and operational then the current agency shall continue to  
5 exist through June 30, 2025, at which time all powers and duties to enforce rules are transferred to  
6 the insurance commissioner or any other applicable state agency or division. If the company  
7 created in §5-16A-1 *et seq.* is not created or is not operational then the agency shall retain all  
8 powers and duties to enforce the rules adopted by the agency until such time as the company  
9 created in §5-16A-1 *et seq.* is created and is operational. These plans shall include:

10 (1) Coverages and benefits for x-ray and laboratory services in connection with  
11 mammograms when medically appropriate and consistent with current guidelines from the United

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

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

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

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

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

(6) Coverage for treatment of serious mental illness:

(A) The coverage does not include custodial care, residential care, or schooling. For purposes of this section, "serious mental illness" means an illness included in the American

Psychiatric Association's diagnostic and statistical manual of mental disorders, as periodically revised, under the diagnostic categories or subclassifications of:

(i) Schizophrenia and other psychotic disorders;

(ii) Bipolar disorders;

(iii) Depressive disorders;

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

(v) Anxiety disorders; and

(vi) Anorexia and bulimia.

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

(B) Notwithstanding any other provision in this section to the contrary, if the agency or the company created pursuant to §5-16A-1 et seq. demonstrates that its total costs for the treatment of mental illness for any plan exceeds two percent of the total costs for such plan in any experience period, then the agency or the company created pursuant to §5-16A-1 et seq. may apply whatever additional cost-containment measures may be necessary in order to maintain costs below two percent of the total costs for the plan for the next experience period. These measures may include, but are not limited to, limitations on inpatient and outpatient benefits.

~~(B)~~ (C) The agency or the company created pursuant to §5-16A-1 et seq. shall may not discriminate between medical-surgical benefits and mental health benefits in the administration of its plan. With regard to both medical-surgical and mental health benefits, it may make determinations of medical necessity and appropriateness and it may use recognized health care quality and cost management tools including, but not limited to, limitations on inpatient and outpatient benefits, utilization review, implementation of cost-containment measures, preauthorization for certain treatments, setting coverage levels, setting maximum number of visits

64 within certain time periods, using capitated benefit arrangements, using fee-for-service  
65 arrangements, using third-party administrators, using provider networks, and using patient cost  
66 sharing in the form of copayments, deductibles, and coinsurance. Additionally, the agency or the  
67 company created pursuant to §5-16A-1 et seq. shall comply with the financial requirements and  
68 quantitative treatment limitations specified in 45 CFR 146.136(c)(2) and (c)(3), or any successor  
69 regulation. The agency or the company created pursuant to §5-16A-1 et seq. may not apply any  
70 nonquantitative treatment limitations to benefits for behavioral health, mental health, and  
71 substance use disorders that are not applied to medical and surgical benefits within the same  
72 classification of benefits: *Provided*, That any service, even if it is related to the behavioral health,  
73 mental health, or substance use diagnosis if medical in nature, shall be reviewed as a medical  
74 claim and undergo all utilization review as applicable;

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

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

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

88 (8) (A) All plans shall include coverage for diagnosis, evaluation, and treatment of autism  
89 spectrum disorder in individuals ages 18 months to 18 years. To be eligible for coverage and

benefits under this subdivision, the individual must be diagnosed with autism spectrum disorder at age eight or younger. Such plan shall provide coverage for treatments that are medically necessary and ordered or prescribed by a licensed physician or licensed psychologist and in accordance with a treatment plan developed from a comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism spectrum disorder.

(B) The coverage shall include, but not be limited to, applied behavior analysis which shall be provided or supervised by a certified behavior analyst. This subdivision does not limit, replace, or affect any obligation to provide services to an individual under the Individuals with Disabilities Education Act, 20 U. S. C. §1400 *et seq.*, as amended from time to time, or other publicly funded programs. Nothing in this subdivision requires reimbursement for services provided by public school personnel. To the extent that the application of this subdivision for autism spectrum disorder causes an increase of at least one percent of actual total costs of coverage for the plan year, the agency may apply additional cost containment measures.

(C) The certified behavior analyst shall file progress reports with the agency semiannually. In order for treatment to continue, the agency or the company created pursuant to §5-16A-1 *et seq.* must receive objective evidence or a clinically supportable statement of expectation that:

- (i) The individual's condition is improving in response to treatment;
- (ii) A maximum improvement is yet to be attained; and
- (iii) There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

(D) To the extent that the provisions of this subdivision require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of insurance plans offered by the Public Employees Insurance Agency or the company created pursuant to §5-16A-1 *et seq.*

(9) For plans that include maternity benefits, coverage for the same maternity benefits for



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

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

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

(ii) Severe food protein-induced enterocolitis syndrome;

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

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

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

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

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

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

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

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

(b) The agency or the company created pursuant to §5-16A-1 et seq. shall make available to each eligible employee, at full cost to the employee, the opportunity to purchase optional group life and accidental death insurance as established under the rules of the agency. In addition, each employee is entitled to have his or her spouse and dependents, as defined by the rules of the agency, included in the optional coverage, at full cost to the employee, for each eligible dependent.

(c) The finance board or the company created pursuant to §5-16A-1 et seq. may cause to be separately rated for claims experience purposes:

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

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

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

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

(d) The agency or the company created pursuant to §5-16A-1 et seq. of this code shall

maintain the medical and prescription drug coverage for Medicare- eligible retirees by providing coverage through one of the existing plans or by enrolling the Medicare-eligible retired employees into a Medicare-specific plan, including, but not limited to, the Medicare/Advantage Prescription Drug Plan. If a Medicare-specific plan is no longer available or advantageous for the agency and the retirees, the retirees remain eligible for coverage through the agency or the company created pursuant to §5-16A-1 et seq. Additionally, if the company created in §5-16A-1 et seq. is created and operational any group plan offered by the company shall be required to contain and provide coverage for all of the provisions set forth in this section.

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

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

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

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

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

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

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

(i) On or after June 1, ~~2024~~ 2025, and annually thereafter, the Public Employees Insurance Agency shall submit a written report to the Joint Committee on Government and Finance that contains the following information regarding plans offered pursuant to this section:

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

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

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

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

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

(4) The results of analyses demonstrating that, for medical necessity criteria described in subdivision (2) of this subsection and for each nonquantitative treatment limitation identified in subdivision (3) of this subsection, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to benefits for behavioral health, mental health, and substance

use disorders within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits;

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

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

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

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

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

(E) Disclose the specific findings and conclusions reached by the Public Employees Insurance Agency that the results of the analyses indicate that each health benefit plan offered by

the Public Employees Insurance Agency complies with paragraph (B), subdivision (6), subsection (a) of this section; and

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

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

**§5-16-7a. Additional mandated benefits; third party reimbursement for colorectal cancer**

**examination and laboratory testing.**

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

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

(c) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered person

may apply to colorectal cancer examinations and laboratory testing.

(d) If the company created in §5-16A-1 et seq. is created and operational any group plan offered by the company shall be required to contain and provide coverage for all of the provisions set forth in this section.

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

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

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

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

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

(b) The plan may not:

(1) Deny a patient eligibility, or continued eligibility, to enroll or renew coverage under the

terms of the plan, solely for the purpose of avoiding the requirements of this section; and

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

(c) If the company created in §5-16A-1 et seq. is created and operational any group plan offered by the company shall be required to contain and provide coverage for all of the provisions set forth in this section.

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

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

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

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

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

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

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

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

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

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

(A) One of the national institutes of health;

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

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



18 exemption;

19 (D) The federal department of Veterans Affairs; or

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

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

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

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

28 (6) The treatment is provided in this state: *Provided*, That, if the treatment is provided  
29 outside of this state, the treatment must be approved by the payor designated in subsection (a) of  
30 this section;

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

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

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

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

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

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

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

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

(h) If the company created in §5-16A-1 et seq. is created and operational any group plan offered by the company shall be required to contain and provide coverage for all of the provisions set forth in this section.

#### **§5-16-7e.**

#### **Definitions.**

[Repealed.]

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

The insurance plans provided for in this article shall be designed by the ~~Public Employees Insurance agency~~ or the company created pursuant to §5-16A-1 et seq.:

(1) To provide a reasonable relationship between the hospital, surgical, medical, and prescription drug benefits to be included and the expected reasonable and customary hospital, surgical, medical, and prescription drug expenses as established by the director to be incurred by the affected employee, his or her spouse, and his or her dependents. The establishment of reasonable and customary expenses by the ~~Public Employees Insurance agency~~ or the company created pursuant to §5-16A-1 et seq. pursuant to the preceding sentence is not subject to chapter §29A-1-1 et seq. of this code;

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

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

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

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

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

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

(8) To provide a cash incentive plan for employees, spouses, and dependents to increase utilization of, and to encourage the use of, lower cost alternative health care facilities, health care providers, and generic drugs. The plan shall be reviewed annually by the director and the advisory board or the company created pursuant to §5-16A-1 et seq.:

(9) To provide health and wellness programs and resources impacting various components of health and wellness. ~~PEIA~~ The agency may explore, review, evaluate, and offer a variety of health and wellness programming and resources to meet the needs of its members. The Division of Vocational Rehabilitation shall continue to provide cooperation with the agency in connection with the "wellness" program until the company established in §5-16A-1 et seq. becomes operational. These programs are voluntary for participants and are separate and distinct from any medical benefit;

(10) To provide a program, to be administered by the director or the company created pursuant to §5-16A-1 et seq., for a patient audit plan with reimbursement up to a maximum of \$1,000 annually to employees for discovery of health care provider or hospital overcharges when the affected employee brings the overcharge to the attention of the plan. The hospital or health care provider shall certify to the director that it has provided, prior to or simultaneously with the

submission of the statement of charges for payments, an itemized statement of the charges to the employee participant for which payment is requested of the plan;

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

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

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

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

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

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

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

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

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

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

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

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

(b) The provisions of §5A-3-1 *et seq.* of this code, relating to the Division of Purchasing of the Department of Finance and Administration, ~~shall~~ may not apply to any contracts for any insurance coverage or professional services authorized to be executed under the provisions of this article. Before entering into any contract for any insurance coverage, as authorized in this

7 article, the director shall invite competent bids from all qualified and licensed insurance companies  
8 or carriers that may wish to offer plans for the insurance coverage desired. The director shall  
9 negotiate and contract directly with health care providers and other entities, organizations, and  
10 vendors in order to secure competitive premiums, prices, and other financial advantages. The  
11 director shall deal directly with insurers or health care providers and other entities, organizations,  
12 and vendors in presenting specifications and receiving quotations for bid purposes. No  
13 commission or finder's fee, or any combination thereof, ~~shall~~ may be paid to any individual or  
14 agent: *Provided*, That this shall not preclude an underwriting insurance company or companies, at  
15 their own expense, from appointing a licensed resident agent within this state to service the  
16 companies' contracts awarded under the provisions of this article. Commissions reasonably  
17 related to actual service rendered for the agent or agents may be paid by the underwriting  
18 company or companies. In no event ~~shall~~ may payment be made to any agent or agents when no  
19 actual services are rendered or performed. The director shall award the contract or contracts on a  
20 competitive basis. In awarding the contract or contracts the director shall consider the experience  
21 of the offering agency, corporation, insurance company, or service organization in the group  
22 hospital and surgical insurance field, group major medical insurance field, group prescription drug  
23 field, and group life and accidental death insurance field, and its facilities for the handling of claims.  
24 In evaluating these factors, the director may employ the services of impartial, professional  
25 insurance analysts or actuaries, or both. Any contract executed by the director with a selected  
26 carrier shall be a contract to govern all eligible employees subject to the provisions of this article.  
27 Nothing contained in this article ~~shall~~ may prohibit any insurance carrier from soliciting employees  
28 covered hereunder to purchase additional hospital and surgical, major medical, or life and  
29 accidental death insurance coverage.

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

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

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

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

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

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

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

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

(A) The cost of drug reimbursement;

(B) Dispensing fees;

(C) Copayments; and

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

(E) Date of service;

(F) NDC-11;

59 (G) Drug name;  
60 (H) Drug strength;  
61 (I) Quantity;  
62 (J) Days of therapy;  
63 (K) Rx count;  
64 (L) Mail/retail code;  
65 (M) Brand/generic indicator;  
66 (N) Specialty drug indicator;  
67 (O) Compound indicator;  
68 (P) Formulary indicator;  
69 (Q) Gross cost;  
70 (R) Member cost;  
71 (S) Plan cost;  
72 (T) Dispense as written;  
73 (U) Pharmacy NPI number;  
74 (V) Pharmacy Claim ID;  
75 (W) Prescriber NPI number;  
76 (X) Pharmacy name; and  
77 (Y) Ingredient cost.

78 In the event there is a difference between the amount for any pharmacy claim paid to the  
79 pharmacy provider and the amount reimbursed to the agency, the pharmacy benefit manager shall  
80 report an itemization of all administrative fees, rebates, or processing charges associated with the  
81 claim. ~~The director shall provide an annual~~ All data and information provided by the pharmacy  
82 benefit manager shall be kept secure, and notwithstanding any other provision of this code to the  
83 contrary, the agency shall maintain the confidentiality of the proprietary information and not share  
84 or disclose the proprietary information contained in the report or data collected with persons



85 outside the agency. All data and information provided by the pharmacy benefit manager shall be  
86 considered proprietary and confidential and exempt from disclosure under the West Virginia  
87 Freedom of Information Act pursuant to §29B-1-4(a)(1). Only those agency employees involved in  
88 collecting, securing, and analyzing the data for the purpose of preparing the report provided for  
89 herein shall have access to the proprietary data. The director shall provide a quarterly report to the  
90 Joint Committee on Health detailing the information required by this section, including any  
91 difference or spread between the overall amount paid by pharmacy benefit managers to the  
92 pharmacy providers and the overall amount charged to the agency for each claim by the pharmacy  
93 benefit manager. To the extent necessary, the director shall use aggregated, nonproprietary data  
94 only: *Provided*, That the director must provide a clear and concise summary of the total amounts  
95 charged to the agency and reimbursed to pharmacy providers on an annual basis.

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

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

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

103 (1) The pharmacy benefit manager shall disclose all information and data related to  
104 contracting, reimbursement, networks, rebates, fees, and any other information and data  
105 requested by the Public Employees Insurance Agency, the Legislature, and vendors for the  
106 purpose of performing study and analysis. Effective with the changes made to this section during  
107 the regular session of the Legislature, 2024, a comprehensive pharmacy business intelligence  
108 study and analysis shall be conducted by an organization with expertise in studying and analyzing  
109 pharmacy benefit managers to determine what, if any, changes could be made to facilitate savings  
110 with respect to the Public Employees Insurance Agency's pharmacy benefit manager services. A

111 final report, including recommendations, shall be presented no later than December 31, 2024, to  
112 the Public Employees Insurance Agency and the Joint Committee on Government and Finance.

113 (2) A pharmacy benefit manager shall not reimburse a West Virginia pharmacy or  
114 pharmacist for a prescription drug or pharmacy service in an amount less than the national  
115 average drug acquisition cost for a prescription drug or pharmacy service at the time the drug is  
116 administered or dispensed, plus a professional dispensing fee at least equal to the professional  
117 dispensing fee paid by West Virginia Medicaid for outpatient drugs. Increases to the professional  
118 dispensing fee may be set by the Director in accordance with this subdivision: *Provided*, That if the  
119 national average drug acquisition cost is not available at the time a drug is administered or  
120 dispensed, a pharmacy benefit manager may not reimburse a West Virginia pharmacy or  
121 pharmacist in an amount that is less than the wholesale acquisition cost of the drug, as defined in  
122 42 U.S.C. § 1395w-3a(c)(6)(B), plus a dispensing fee as described in this subdivision. A West  
123 Virginia pharmacy is a domestic business entity as registered with the West Virginia Secretary of  
124 State. The provisions in this subdivision shall be effective for the Public Employees Insurance  
125 Agency plan year beginning on July 1, 2024.

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

4 ~~In the event~~ If the ~~Public Employees Insurance Agency~~ agency provides the above  
5 benefits for retired employees, their spouses, and dependents, the ~~Public Employees Insurance~~  
6 ~~Agency~~ agency shall adopt rules and regulations prescribing the conditions under which retired  
7 employees may elect to participate in or withdraw from the plan or plans. Any plan provided for  
8 shall be secondary to any insurance plan administered by the United States Department of Health

and Human Services to which the retired employee, spouse, or dependent may be eligible under any law or regulation of the United States. If an employee eligible to participate in the ~~Public Employees Insurance Agency~~ agency plans is also eligible to participate in the state Medicaid program, and chooses to do so, then the ~~Public Employees Insurance Agency~~ agency may transfer to the Medicaid program funds to pay the required state share of such employee's participation in Medicaid except that the amount transferred may not exceed the amount that would be allocated by the agency to subsidize the cost of coverage for the retired employee if he or she were enrolled in the Public Employees Insurance Agency's plans.

**§5-16-11. To whom benefits paid.**

Any benefits payable under a plan may be paid either directly to the medical provider, hospital, medical group, or other person, firm, association, or corporation furnishing the service upon which the claim is based, or to the insured upon presentation of valid bills for such service, subject to such provisions designed to facilitate payments as may be made by the director or the company created pursuant to §5-16A-1 et seq.

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

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

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

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

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

(4) Willfully misrepresent any material fact relating to any other information requested by the director or the company created pursuant to §5-16A-1 et seq.:

10 (5) Willfully overcharge for services provided; or

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

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

15 (b) If, after notice and an administrative proceeding, it is determined the person has  
16 violated the article, the person is liable for any overpayment received. The director or the company  
17 created pursuant to §5-16A-1 et seq. shall withhold and set off any payment of any benefits or  
18 other payment due to that person until any overpayment is recovered.

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

27 (d) Any person who violates any provision of this article which results in a loss to, or  
28 overpayment from, the plan, or to the State of West Virginia of less than \$1,000, and for which no  
29 other penalty is specifically provided, is guilty of a misdemeanor and, upon conviction thereof, is  
30 subject to a fine of not less than \$100 but not more than \$500, or ~~imprisonment~~ confinement in jail  
31 for a period of not less than 24 hours but not more than 15 days, or both fined and confined. Any  
32 person who violates any provision of this article which results in a loss to, or overpayment from, the  
33 plan or the State of West Virginia of \$1,000 or more, and for which no other penalty is specifically  
34 provided, is guilty of a felony and, upon conviction thereof, is subject to a fine of not less than

35 \$1,000 but not more than \$5,000, or imprisonment in a state correctional facility for a period of not  
36 less than one nor more than five years, or both fined and imprisoned.

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

1            (a) Employers and employees participating in any of the ~~Public Employees Insurance~~  
2 ~~Agency~~ agency plans shall provide, to the director or the company created pursuant to §5-16A-1 et  
3 seq., upon request, all documentation reasonably required for the director or the company created  
4 pursuant to §5-16A-1 et seq. to discharge the responsibilities under this article. This  
5 documentation includes, but is not limited to, employment or eligibility records sufficient to verify  
6 actual full-time employment and eligibility of employees who participate in the Public Employees  
7 Insurance Agency plans.

8            (b) Upon a determination of the director or his or her designated representative or the  
9 company created pursuant to §5-16A-1 et seq. that there is probable cause to believe that fraud,  
10 abuse or other illegal activities involving transactions with the agency has occurred, the director or  
11 his or her designated representative or the company created pursuant to §5-16A-1 et seq. is  
12 ~~authorized to~~ may refer the alleged violations to the Insurance Commissioner for investigation  
13 and, if appropriate, prosecution, pursuant to article forty-one, chapter thirty-three of this code. For  
14 purposes of this section, "transactions with the agency" includes, but is not limited to, application  
15 by any insured or dependent, any employer or any type of health care provider for payment to be  
16 made to that person or any third party by the agency.

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

(d) For the purpose of any investigation or proceeding under this article, the director or any officer designated by him or her or the company created pursuant to §5-16A-1 et seq. may administer oaths and affirmations, issue administrative subpoenas, take evidence, and require the production of any books, papers, correspondences, memoranda, agreements or other documents or records which may be relevant or material to the inquiry.

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

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

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

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

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

(a) Cost-sharing. — The director or the company created pursuant to §5-16A-1 et seq. shall provide plans that shall be paid by the employer and employee.

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

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

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

(c) Continuation after termination. — If an employee participating in the plan is terminated from employment involuntarily or in reduction of work force, the employee's insurance coverage

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

(d) Conversion of accrued annual and sick leave for extended insurance coverage upon retirement for employees who elected to participate in the plan before July, 1988. — Except as otherwise provided in subsection (g) of this section, when an employee participating in the plan, who elected to participate in the plan before July 1, 1988, is compelled or required by law to retire before reaching the age of 65, or when a participating employee voluntarily retires as provided by law, that employee's accrued annual leave and sick leave, if any, shall be credited toward an extension of the insurance coverage provided by this article, according to the following formulae: The insurance coverage for a retired employee shall continue one additional month for every two days of annual leave or sick leave, or both, which the employee had accrued as of the effective date of his or her retirement. For a retired employee, his or her spouse and dependents, the insurance coverage shall continue one additional month for every three days of annual leave or sick leave, or both, which the employee had accrued as of the effective date of his or her retirement. (e) Conversion of accrued annual and sick leave for extended insurance coverage upon retirement for employees who elected to participate in the plan after June, 1988. — Notwithstanding subsection (d) of this section, and except as otherwise provided in subsections



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

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

shall not be used in meeting initial eligibility for retirement criteria, but only as additional service credited in excess thereof.

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

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

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

(j) Elected officials. — In construing the provisions of this section or any other provisions of

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

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

108 (l) Prohibition on conversion of accrued annual and sick leave for extended coverage upon  
109 retirement for new employees who elect to participate in the plan after June, 2001. — Any  
110 employee hired on or after July 1, 2001, who elects to participate in the plan may not apply accrued  
111 annual or sick leave toward the cost of premiums for extended insurance coverage upon his or her  
112 retirement. This prohibition does not apply to the conversion of accrued annual or sick leave for  
113 increased retirement benefits, as authorized by this section: *Provided*, That any person who has  
114 participated in the plan prior to July 1, 2001, is not a new employee for purposes of this subsection  
115 if he or she becomes reemployed with an employer participating in the plan within two years  
116 following his or her separation from employment and he or she elects to participate in the plan  
117 upon his or her reemployment.

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

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

**and hearing-aid service plan.**

1 (a) The director or the company created pursuant to §5-16A-1 et seq. shall make available  
2 to participants in the public 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 or the company created pursuant to §5-16A-1 et seq. is  
12 ~~authorized to~~ may employ such administrative practices and procedures with respect to these  
13 optional plans as are authorized for the administration of other plans under this article. The director  
14 or the company created pursuant to §5-16A-1 et seq. shall establish separate funds for each of the  
15 above listed plans. The funds shall may not be supplemented by nor be used to supplement any  
16 other funds.

**§5-16-16. Preferred provider plan.**

1 The director or the company created pursuant to §5-16A-1 et seq. shall establish a

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

6 The director or the company created pursuant to §5-16A-1 et seq. shall establish the terms  
 7 of the preferred provider system and the incentives therefor. The terms and incentives may include  
 8 multiyear renewal options as are not prohibited by the Constitution of this state and capitated  
 9 primary care arrangements which are not subject to the provisions of §33-25A-1 et seq. of this  
 10 code.

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

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

4 For all participants enrolling in the plan after the effective date of this section, payment  
 5 shall be made for expenses incurred for or in connection with a preexisting condition: *Provided,*  
 6 That participants may enroll or make plan selections only at the time of hire, during annual open  
 7 enrollment or upon the occurrence of a "qualifying event" under section 125 of the United States  
 8 Internal Revenue 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~~ agency or the company created pursuant to §5-16A-1 et  
 4 seq. to current and retired employees of the employer as a separate line item titled PEIA in its  
 5 respective annual budget and are responsible for the transfer of funds to the director or the  
 6 company created pursuant to §5-16A-1 et seq. for the cost of insurance for employees covered by

7 the plan. Each spending unit shall pay to the director or the company created pursuant to §5-16A-1  
8 et seq. its proportionate share from each source of funds. Any agency wishing to charge General  
9 Revenue Funds for insurance benefits for retirees under §5-16-13 of this code shall provide  
10 documentation to the director or the company created pursuant to §5-16A-1 et seq. that the  
11 benefits cannot be paid for by any special revenue account or that the retiring employee has been  
12 paid solely with General Revenue Funds for 12 months prior to retirement.

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

23 (c) All other employers not operating from the state General Revenue Fund shall pay to the  
24 director or the company created pursuant to §5-16A-1 et seq. their share of premium costs from  
25 their respective budgets. The finance board or the company created pursuant to §5-16A-1 et seq.  
26 shall establish the employers' share of premium costs to reflect and pay the actual costs of the  
27 coverage including incurred but not reported claims.

28 (d) The contribution of the other employers that are counties, cities, or towns in the state;  
29 any separate corporation or instrumentality established by one or more counties, cities, or towns,  
30 as permitted by law; any corporation or instrumentality supported in most part by counties, cities or  
31 towns; any public corporation charged by law with the performance of a governmental function and  
32 whose jurisdiction is coextensive with one or more counties, cities, or towns; any comprehensive

community mental health center or comprehensive mental health facility established, operated, or licensed by the Secretary of the Department of Health and Human Resources pursuant to §27-2A-1 *et seq.* of this code, and which is supported in part by state, county, or municipal funds; and a combined city-county health department created pursuant to §16-2-1 *et seq.* of this code for their employees shall be the percentage of the cost of the employees' insurance package as the employers determine reasonable and proper under their own particular circumstances.

(e) The employee's proportionate share of the premium or cost shall be withheld or deducted by the employer from the employee's salary or wages as and when paid and the sums shall be forwarded to the director or the company created pursuant to §5-16A-1 *et seq.* with any supporting data as the director may require.

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

(g) The ~~Public Employees Insurance Agency~~ agency or the company created pursuant to §5-16A-1 *et seq.* may recover an additional interest amount from any employer that fails to pay in a timely manner any premium or minimum annual employer payment, as defined in §5-16D-1 *et seq.* of this code, which is due and payable to the ~~Public Employees Insurance Agency~~ agency or the company created pursuant to §5-16A-1 *et seq.* or the Retiree Health Benefit Trust. The agency or the company created pursuant to §5-16A-1 *et seq.* may recover the amount due plus an additional amount equal to 2.5 percent per annum of the amount due. Accrual of interest owed by the

delinquent employer commences upon the 31st day following the due date for the amount owed and shall continue until receipt by the ~~Public Employees Insurance Agency~~ agency or the company created pursuant to §5-16A-1 et seq. of the delinquent payment. Interest shall compound every 30 days.

(h) Any special revenue account created pursuant to this article shall terminate upon termination of the agency and its proceeds shall be distributed as set forth in §5-16A-1 et seq.

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

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

(b) The rules shall provide that any employee of the state who has been compelled or required by law to retire before reaching the age of sixty-five years is eligible to participate in the public employees' health insurance program at the premium contribution established by the finance board after any extended coverage to which he or she, his or her spouse and dependents may be entitled by virtue of his or her accrued annual leave or sick leave, pursuant to the provisions of section thirteen of this article, has expired. Any employee who voluntarily retires, as provided by law, is eligible to participate in the public employees' health insurance program at the premium contribution established by the finance board after any extended coverage to which he or she, his or her spouse and dependents may be entitled by virtue of his or her accrued annual leave or sick leave, pursuant to the provisions of section thirteen of this article, has expired: *Provided*, That the employee's last employer is a participating employer. The dependents of any deceased



retired employee are entitled to continue their participation and coverage upon payment of the premium contribution established by the finance board or the company created pursuant to §5-16A-1 et seq. In establishing the cost of health insurance coverage for retired employees and their spouses and dependents, the finance board or the company created pursuant to §5-16A-1 et seq., ~~in its discretion~~ may cause the claims experience of the retired employees and their spouses and dependents to be rated separately from that of active employees and their spouses and dependents, or may cause the claims experience of retired and active employees, and their spouses and dependents, to be rated together.

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

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

(e) If the company created in §5-16A-1 et seq. is created and operational then the current agency shall continue to exist through June 30, 2025, at which time all powers and duties to enforce any rules adopted by the agency are transferred to the Insurance Commissioner or any other applicable state agency or division. If the company created in §5-16A-1 et seq. is not created or is not operational then the agency shall retain all powers and duties to enforce the rules adopted

44 by the agency until such time as the company created in §5-16A-1 *et seq.* is created and is  
45 operational.

**ARTICLE 16A. PUBLIC EMPLOYEES MUTUAL INSURANCE COMPANY.**

**§5-16A-1. Findings and purpose.**

1 The Legislature finds:

2 (1) That it is the intention of the state to provide comprehensive and essential package  
3 health insurance to its employees;

4 (2) That although West Virginia Public Employees Insurance Agency continues to strive to  
5 serve all those persons covered by the plans, it finds that it continues to operate at a deficit;

6 (3) That to ensure that the employees of the State of West Virginia continue to have a  
7 viable and financially sound insurance program, a new and innovative approach to offering  
8 insurance to state employees is necessary;

9 (4) There currently exist an actuarial funding crisis in the Public Employees Insurance  
10 Agency;

11 (5) There is a belief that a privately operated public employees' mutual insurance agency  
12 or a similar entity would stabilize the insurance for public employees; and

13 (6) That allowing the Public Employees Insurance Agency to offer a product that competes  
14 on the open insurance market will help solidify the programs offered and make them more  
15 financially viable to ensure the continued delivery of health insurance to employees of the state of  
16 West Virginia.

**§5-16A-2. Definitions.**

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

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

4 "Applied behavior analysis" means the design, implementation and evaluation of  
5 environmental modifications using behavioral stimuli and consequences in order to produce

socially significant improvement in human behavior and includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

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

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

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

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

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

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

"Company" or "successor to the agency" means the Public Employees Mutual Insurance Company created pursuant to the terms of this article.

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

A cooperative group includes:

(1) The national cancer institute clinical cooperative group;

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

32 (3) The AIDS clinical trial group; and

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

34 "FDA" means the federal Food and Drug Administration.

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

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

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

47 "Emergency services" means those services required to screen for or treat an emergency  
48 medical condition until the condition is stabilized, including prehospital care;

49 "Employee" means any person, including an elected officer, who works regularly full time in  
50 the service of the State of West Virginia and, for the purpose of this article only, the term  
51 "employee" also means any person, including an elected officer, who works regularly full time in  
52 the service of a county board of education; a county, city or town in the state; any separate  
53 corporation or instrumentality established by one or more counties, cities or towns, as permitted by  
54 law; any corporation or instrumentality supported in most part by counties, cities or towns; any  
55 public corporation charged by law with the performance of a governmental function and whose  
56 jurisdiction is coextensive with one or more counties, cities or towns; any comprehensive  
57 community mental health center or comprehensive mental retardation facility established,

operated or licensed by the Secretary of Health and Human Resources pursuant to §27-2A-1 and which is supported in part by state, county or municipal funds; any person who works regularly full time in the service of the Higher Education Policy Commission, the West Virginia Council for Community and Technical College Education or a governing board, as defined in §18B-1-2; any person who works regularly full time in the service of a combined city-county health department created pursuant to 116-2-1 *et seq.*; any person designated as a 21st Century Learner Fellow pursuant to §18A-3-11; and any person who works as a long-term substitute as defined in §18A-1-1 in the service of a county board of education: *Provided, That* a long-term substitute who is continuously employed for at least 133 instructional days during an instructional term, and until the end of that instructional term, is eligible for the benefits provided in this article until September 1, following that instructional term: *Provided, however, That* a long-term substitute employed fewer than 133 instructional days during an instructional term is eligible for the benefits provided in this article only during such time as he or she is actually employed as a long-term substitute. On and after January 1, 1994, and upon election by a county board of education to allow elected board members to participate in the Public Employees Insurance Program pursuant to this article, any person elected to a county board of education shall be considered to be an "employee" during the term of office of the elected member. Upon election by the state Board of Education to allow appointed board members to participate in the Public Employees Insurance Program pursuant to this article, any person appointed to the state Board of Education is considered an "employee" during the term of office of the appointed member: *Provided further, That* the elected member of a county board of education and the appointed member of the state Board of Education shall pay the entire cost of the premium if he or she elects to be covered under this article. Any matters of doubt as to who is an employee within the meaning of this article shall be decided by the director.

A person shall be considered an "employee" if that person meets the following criteria:

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

(2) Has been designated, in writing, by all other participants in that job-sharing

84 arrangement as the "employee" for purposes of this section; and

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

86 "Employer" means the State of West Virginia, its boards, agencies, commissions,  
87 departments, institutions or spending units; a county board of education; a county, city or town in  
88 the state; any separate corporation or instrumentality established by one or more counties, cities  
89 or towns, as permitted by law; any corporation or instrumentality supported in most part by  
90 counties, cities or towns; any public corporation charged by law with the performance of a  
91 governmental function and whose jurisdiction is coextensive with one or more counties, cities or  
92 towns; any comprehensive community mental health center or comprehensive mental retardation  
93 facility established, operated or licensed by the Secretary of Health and Human Resources  
94 pursuant to §27-2A-1 and which is supported in part by state, county or municipal funds; a  
95 combined city-county health department created pursuant to §16-2-1 et seq.; and a corporation  
96 meeting the description set forth in §18B-12-3 that is employing a 21st Century Learner Fellow  
97 pursuant to §18-3-11 but the corporation is not considered an employer with respect to any  
98 employee other than a 21st Century Learner Fellow. Any matters of doubt as to who is an  
99 "employer" within the meaning of this article shall be decided by the director. The term "employer"  
100 does not include within its meaning the National Guard.

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

103 "Insurance Commissioner" means the Insurance Commissioner of West Virginia as  
104 provided in §33-2-1.

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

108 "Medical screening examination" means an appropriate examination within the capability  
109 of the hospital's emergency department, including ancillary services routinely available to the

emergency department, to determine whether or not an emergency medical condition exists; and

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

"Multiple project assurance contract" means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

"Mutualization transition fund" means a fund over which the State Treasurer is custodian. Moneys transferred or otherwise payable to the Mutualization Transition Fund shall be deposited in the State Treasury to the credit of the Mutualization Transition Fund. Disbursements shall be made from the Mutualization Transition Fund upon requisitions signed by the director, and, upon termination of the agency, the Insurance Commissioner, and shall be reasonably related to the legal, operational, consultative and human resource related expenses associated with the establishment of the company and the transferring of personnel from the agency to the company.

"NIH" means the National Institutes of Health.

"New fund" means a fund owned and operated by the agency and, upon termination of the agency, the successor organization of the West Virginia Public Employees Insurance Agency and shall consist of those funds transferred to it from the Public Employees Insurance Fund and any other applicable funds. New fund shall include all moneys due and payable to the Public Employee's Insurance Agency as of June 30, 2025.

"New fund liabilities" means all claims payment obligations (indemnity and medical expenses) for all claims, actual and incurred but not reported, for any claim with a date of injury or last exposure on or after July 1, 2025.

"Old fund" means a fund held by the state treasurer's office consisting of those funds transferred to it from the Public Employees Agency Fund or other sources and those funds due and owing the Public Employees Insurance Fund as of June 30, 2025, that are thereafter

collected. The old fund and assets therein shall remain property of the state and may not novate or otherwise transfer to the company.

"Old fund liabilities" mean all claims payment obligations (indemnity and medical expenses), related liabilities and appropriate administrative expenses necessary for the administration of all claims, actual and incurred but not reported, for any claim with a date of injury or last exposure on or before June 30, 2025.

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

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

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

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

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

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

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

(6) Adverse events during treatment are divided into those that reflect the natural history of



the disease, or its progression, and those that are unique in the experimental treatment. Costs for the former are the responsibility of the payor as provided in §5-16A-2, and costs for the later are the responsibility of the sponsor. The sponsor shall hold harmless any payor for any losses and injuries sustained by any member as a result of his or her participation in the clinical trial.

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

"Plan", unless the context indicates otherwise, means the medical indemnity plan, the managed care plan option or the group life insurance plan offered by the agency.

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

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

"Private carrier" means any insurer or the legal representative of an insurer authorized by the insurance commissioner to provide public employees insurance pursuant to this article and which maintains an office in the state.

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

condition exists for which emergency treatment should be sought;

"Public employees insurance" means insurance which provides health and surgical care coverage to plan participants as set forth in this article;

"Public Employees Insurance Council" means the council set forth in §5-16A-5;

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

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

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

**§5-16A-3. Creation of the Public Employees Mutual Insurance Company as successor organization of the West Virginia Public Employees Insurance Agency.**

(a) On or before July 1, 2025, the director may take such actions as are necessary to establish a Public Employees Mutual Insurance Company as a domestic, private, nonstock, corporation to:

(1) Establish a group hospital and surgical insurance plan or plans;

(2) A group prescription drug insurance plan or plans;

(3) A group major medical insurance plan or plans; and,

(4) A group life and accidental death insurance plan or plans for state employees as they are defined in this article.

(5) Transact such other kinds of insurance for which the company is otherwise qualified under the provisions of this code.

(6) The company may not sell, assign or transfer substantial assets or ownership of the company.

(b) If the director establishes a domestic mutual insurance company pursuant to

14 subsection (a) of this section:

15 (1) As soon as practical, the company established pursuant to the provisions of this article  
16 shall, through a vote of a majority of its provisional board, file its corporate charter and bylaws with  
17 the Insurance Commissioner and apply for a license with the Insurance Commissioner to transact  
18 insurance business in this state. Notwithstanding any other provision of this code, the Insurance  
19 Commissioner shall act on the documents within 15 days of the filing by the company.

20 (2) In recognition of the critical nature of the financial standing of the Public Employees  
21 Insurance Agency in this state at the time of enactment of this article and the critical need to  
22 expedite the initial operation of the company, the Legislature hereby authorizes the Insurance  
23 Commissioner to review the documentation submitted by the company and to determine the initial  
24 capital and surplus requirements of the company, notwithstanding the provisions of §33-3-5b. The  
25 company shall furnish the Insurance Commissioner with all information and cooperate in all  
26 respects necessary for the Insurance Commissioner to perform the duties set forth in this section  
27 and in other provisions of this article and chapter 33 of this code. The Insurance Commissioner  
28 shall monitor the economic viability of the company during its initial operation on not less than a  
29 monthly basis, until such time as the Insurance Commissioner determines that monthly reporting  
30 is not necessary. In all other respects the company shall be subject to comply with the applicable  
31 provisions of chapter 33 of this code.

32 (3) Subject to the provisions of subsection (4) of this section, the Insurance Commissioner  
33 may waive other requirements imposed on mutual insurance companies by the provisions of  
34 chapter 33 of this code as the Insurance Commissioner determines is necessary to enable the  
35 company to begin insuring individuals in this state at the earliest possible date.

36 (4) Within 40 months of the date of the issuance of its license to transact insurance, the  
37 company shall comply with the capital and surplus requirements set forth in §33-3-5b (a) in effect  
38 on the effective date of this enactment, unless said deadline is extended by the Insurance  
39 Commissioner.

(c) For the duration of its existence, the company is not and may not be considered a department, unit, agency, or instrumentality of the state for any purpose. All debts, claims, obligations, and liabilities of the company, whenever incurred, shall be the debts, claims, obligations, and liabilities of the company only and not of the state or of any department, unit, agency, instrumentality, officer or employee of the state.

(d) The moneys of the company are not and may not be considered part of the General Revenue Fund of the state. The debts, claims, obligations, and liabilities of the company are not and may not be considered a debt of the state or a pledge of the credit of the state.

(e) The company is not subject to §6-9A-1 et seq.; the provisions of chapter 29B of this code; the provisions of §5A-3-1 et seq.; the provisions of §29-6-1 et seq.; the provisions of §29-6A-1 et seq.; or the provisions of chapter 12 of this code.

(f) The company shall be subject to the payment of premium taxes, surcharges and credits contained in chapter 33 of this code.

**§5-16A-4. Governance and organization.**

(a) (1) The agency shall implement the initial formation and organization of the company as provided by this article.

(2) From the inception of the company, until December 31, 2025, the company shall be governed by a provisional board of directors consisting of the three persons on the Public Employees Finance Board and four members of the Legislature. Two members of the West Virginia Senate and two members of the West Virginia House of Delegates shall serve as advisory nonvoting members of the board. The Governor shall appoint the legislative members to the board. No more than three of the legislative members shall be of the same political party. The provisional board shall have the authority to function as necessary to establish the company and cause it to become operational, including the right to contract on behalf of the company. Each voting board member shall receive compensation of not more than \$500 per day and actual and necessary expenses for each day during which he or she is required to and does attend a meeting

13 of the board.

14 (3) The provisional board shall develop procedures for the nomination of the board of  
15 directors that will succeed the provisional board on January 1, 2025, and for the conduct of the  
16 election, to be held no later than May 1, 2025, and shall give notice of the election to the current  
17 subscribers to the Workers' Compensation Fund. These procedures shall be exempt from the  
18 provisions of §29A-3-1 et seq. of this code.

19 (4) Except as limited by this section and applicable insurance rules and statutes, the  
20 company may: (1) On its own; (2) through the formation or acquisition of subsidiaries; or (3)  
21 through a joint enterprise, offer:

22 (A) Health insurance, surgical insurance plans, group major medical insurance plans,  
23 group prescription drug plans and group life and accidental death insurance plans in a state other  
24 than West Virginia to the extent it also overs substantially similar insurance coverage to the public  
25 employees of this state pursuant to this chapter;

26 (B) Health insurance products, surgical insurance plans, group major medical insurance  
27 plans, group prescription drug plans and group life and accidental death insurance plans and  
28 services and related products and services in West Virginia or other states; and

29 (C) Other types of insurance in West Virginia and other states.

30 (b) Effective July 1, 2025, the company shall be governed by a board of directors  
31 consisting of seven directors, as follows:

32 (1) Two directors shall have substantial experience as an officer or employee of a company  
33 in the insurance industry, one of whom is from a company with less than 50 employees;

34 (2) One shall be a certified public accountant with financial management or pension or  
35 insurance audit expertise;

36 (3) One shall be an attorney with financial management experience;

37 (4) One director with general knowledge and experience in business management who is  
38 an officer and employee of the company and is responsible for the daily management of the

company;

(5) One shall be a consumer of served by the products offered by the company; and

(6) The chief executive officer of the company.

(c) The directors and officers of the company are to be chosen in accordance with the articles of incorporation and bylaws of the company. The initial board of directors selected shall serve for the following terms: (1) Two for four-year terms; (2) two for three-year terms; (3) two for two-year terms; and (4) one for a one-year term. Thereafter, the directors shall serve staggered terms of four years. No director chosen may serve more than two consecutive terms, except for the chief executive officer of the company. Furthermore, owners, directors, or employees of employers otherwise licensed to write insurance in this state or licensed or otherwise authorized to act as a third-party administrator may not be eligible to be nominated, appointed, elected or serve on the company's board of directors.

(d) The director shall prepare and file articles of incorporation and bylaws in accordance with the provisions of this article and the provisions of chapters 31 and 33 of this code.

**§5-16A-5. Creation and Duties of the Public Employees Insurance Council.**

(a) There is hereby created the Public Employees Insurance Council within the Insurance Commission.

(b) On or before January 1, 2026, the Governor with the advice and consent of the Senate, shall appoint five voting members to the council who meet the requirements and qualifications of this subsection. Two members of the West Virginia Senate and two members of the West Virginia House of Delegates shall serve as advisory nonvoting members of the board. The Governor shall appoint the legislative members to the board. No more than three of the legislative members may be of the same political party. The Insurance Commissioner shall serve as an advisory nonvoting member of the board.

(1) (A) Five members shall be appointed by the Governor with the advice and consent of the Senate for terms that begin upon appointment after the effective date of this legislation and

12 expire as follows:

13 (i) One member shall be appointed for a term ending June 30, 2027;

14 (ii) Two members shall be appointed for a term ending June 30, 2028; and

15 (iii) Two members shall be appointed for a term ending June 30, 2029.

16 (B) Except for appointments to fill vacancies, each subsequent appointment shall be for a  
17 term ending June 30 of the fourth year following the year the preceding term expired. If a vacancy  
18 occurs, it shall be filled by appointment for the unexpired term. A member whose term has expired  
19 shall continue in office until a successor has been duly appointed and qualified. No member of the  
20 council may be removed from office by the Governor except for official misconduct, incompetency,  
21 neglect of duty or gross immorality.

22 (C) No appointed member may be a candidate for or hold elected office. Members may be  
23 reappointed for no more than two full terms.

24 (2) Each of the appointed voting members of the council shall be appointed based upon his  
25 or her demonstrated knowledge and experience to effectively accomplish the purposes of this  
26 article. They shall meet the minimum qualifications as follows:

27 (A) Each shall hold a baccalaureate degree from an accredited college or university:  
28 Provided, That no more than one of the appointed voting members may serve without a  
29 baccalaureate degree from an accredited college or university if the member has a minimum of  
30 fifteen years' experience in his or her field of expertise as required in this subdivision;

31 (B) Each shall have a minimum of ten years' experience in his or her field of expertise. The  
32 Governor shall consider the following guidelines when determining whether potential candidates  
33 meet the qualifications of this subsection: Expertise in insurance claims management; expertise in  
34 insurance underwriting; expertise in the financial management of pensions or insurance plans;  
35 expertise as a trustee of pension or trust funds of more than 200 beneficiaries or \$300 million;  
36 expertise in loss prevention and rehabilitation; expertise in medicine demonstrated by licensure as  
37 a medical doctor in West Virginia and experience, board certification or university affiliation; or



38 expertise in similar areas of endeavor;

39 (C) At least one shall be a certified public accountant with financial management or  
40 pension or insurance audit expertise; at least one shall be an attorney with financial management  
41 experience; one shall be an academician holding an advanced degree from an accredited college  
42 or university in business, finance, insurance or economics; and one shall represent the interest of  
43 public employees.

44 (D) The council shall elect one of its members to serve as chairperson. The chairperson  
45 shall serve for a one-year term and may serve more than one consecutive term. The council shall  
46 hold meetings at the request of the chairperson or at the request of at least three of the members  
47 of the council, but no less frequently than once every three months. The chairperson shall  
48 determine the date and time of each meeting. Three members of the council constitute a quorum  
49 for the conduct of the business of the council. No vacancy in the membership of the council may  
50 impair the right of a quorum to exercise all the rights and perform all the duties of the council. No  
51 action may be taken by the council except upon the affirmative vote of three members of the  
52 council.

53 (3) (A) Each voting appointed member of the council shall receive compensation of not  
54 more than \$500 per day for each day during which he or she is required to and does attend a  
55 meeting of the board.

56 (B) Each voting appointed member of the council shall be reimbursed for actual and  
57 necessary expenses incurred for each day or portion thereof engaged in the discharge of official  
58 duties in a manner consistent with guidelines of the travel management office of the department of  
59 administration.

60 (C) Each member of the council shall be provided appropriate liability insurance, including,  
61 but not limited to, errors and omissions coverage, without additional premium, by the state board  
62 of risk and insurance management established pursuant to §29-12-1 et seq..

63 (c) The council shall:

64           (1) In consultation with the Insurance Commissioner, establish operating guidelines and  
65 policies designed to ensure the effective administration of the Public Employees Insurance Mutual  
66 Insurance Company in West Virginia.

67           (2) Review and approve, reject or modify rules that are proposed by the Insurance  
68 Commissioner for operation and regulation of the Public Employees Mutual Insurance Company  
69 before the rules are filed with the Secretary of State. The rules adopted by the council are not  
70 subject to §29A-3-9 through 16, inclusive, of this code. The council shall follow the remaining  
71 provisions of chapter 29A of this code for giving notice to the public of its actions and for holding  
72 hearings and receiving public comments on the rules.

73           (3) In accordance with the laws and rules of West Virginia, establish and monitor  
74 performance standards and measurements to ensure the timeliness and accuracy of activities  
75 performed under this article and applicable rules.

76           (4) Submit for approval by the Legislature, as an isolated and clearly discernable  
77 component of the Insurance Commissioner's budget, a budget for the sufficient administrative  
78 resources and funding requirements necessary for their duties under this article.

79           (5) Perform all record and information gathering functions necessary to carry out its duties  
80 under this code.

81           (6) Every two years, conduct an overview of the initiatives currently being utilized in the  
82 insurance industry which could be utilized in the operation and management of the company and  
83 report said findings to the Joint Committee on Government and Finance. Each private carrier  
84 licensed and doing business in West Virginia shall cooperate with the council in the performance  
85 of its duties to evaluate insurer services. Each entity of state government, including, but not limited  
86 to, state boards, agencies, commissions, departments, institutions or spending units shall provide  
87 to the council, upon request, any information, statistics or data in its records requested by the  
88 council in the performance of these duties.

89           (7) Perform all other duties as specifically provided in this article for the council and those

90 duties incidental thereto.

91 (d) The Public Employees Insurance Council shall:

92 (1) Review and approve, reject or modify recommendations from the Insurance  
93 Commissioner for the development of overall policy for the administration of this article.

94 (2) In consultation with the Insurance Commissioner, establish operating guidelines and  
95 policies designed to ensure the effective administration of the public employees insurance market  
96 in West Virginia.

97 (3) Review and approve, reject or modify rules that are proposed by the Insurance  
98 Commissioner for operation and regulation of the public employees insurance market before the  
99 rules are filed with the Secretary of State. The rules adopted by the Public Employee Insurance  
100 Council are not subject to §29A-3-9 through 16, inclusive, of this code. The Public Employee  
101 Insurance Council shall follow the remaining provisions of chapter 29 of this code for giving notice  
102 to the public of its actions and for holding hearings and receiving public comments on the rules.

103 (4) In accordance with the laws and rules of West Virginia, establish and monitor  
104 performance standards and measurements to ensure the timeliness and accuracy of activities  
105 performed under chapter 5 of this code and applicable rules.

106 (5) Submit for approval by the Legislature, as an isolated and clearly discernable  
107 component of the Insurance Commissioner's budget, a budget for the sufficient administrative  
108 resources and funding requirements necessary for their duties under this article.

109 (6) Perform all record and information gathering functions necessary to carry out its duties  
110 under this code.

111 (7) On a biannual basis, conduct an overview of the safety initiatives currently being  
112 utilized or which could be utilized in to provide better coverage and functionality of the plans  
113 offered on the public employee insurance market and report said finding to the Joint Committee on  
114 Government and Finance. Other private carriers licensed or doing business in West Virginia shall  
115 cooperate with the council in the performance of its duties to evaluate insurer services provided to

control losses and provide information on the prevention other healthcare initiatives for disease awareness and prevention. Employers and private carriers shall provide to the council, upon request, any information, statistics or data in its records requested by the council in the performance of these duties.

(8) The council shall elect one member to serve as chairperson.

(9) Perform all other duties as specifically provided in this chapter for the industrial council and those duties incidental thereto.

(10) Establish a method of indexing claims that will make information concerning one insurer available to other insurers.

**§5-16A-6. Creation of new fund, old fund, mutualization transition fund and assigned risk fund.**

(a) Effective upon the date upon which this enactment is made effective by the Legislature, there is hereby established in the State Treasury a "Public Employees Old Fund", "Public Employees New Fund", "Mutualization Transition Fund" and an "Assigned Risk Fund". The Director of the Public Employees Insurance Agency has full authority to administer the old fund, the new fund and the mutualization transition fund until termination of the agency. As soon as practicable upon the establishment of the mutualization transition fund, the director shall cause an amount determined by the West Virginia Commissioner of Insurance and approved by the Joint Committee on Government and Finance to be transferred from the Public Employees Insurance fund into the Mutualization Transition Fund. If the proclamation set forth in this article has not been issued, all unencumbered funds remaining in the Mutualization Transition Fund as of termination of the agency shall be transferred back to the Public Employees Insurance Fund.

(b) If the proclamation set forth in this article is issued, then upon termination of the agency, the funds contained in the Public Employees Insurance Fund shall be disbursed with an amount determined by the West Virginia Commissioner of Insurance and approved by the Joint Committee on Government and Finance into the Public Employee Insurance Old Fund, the exact amount of

16 which shall be set forth in the governor's proclamation provided in this article and the remainder  
17 into the new fund.

**§5-16A-7. Custody, investment and disbursement of funds.**

1 (a) The State Treasurer shall be the custodian of the Public Employees Insurance Old  
2 Fund and the Assigned Risk Pool and moneys payable to each of these funds shall be deposited  
3 in the State Treasury to the credit of the funds. Each fund shall be a separate and distinct fund  
4 upon the books and records of the Auditor and Treasurer. Disbursements from these funds shall  
5 be made upon requisitions signed by the director and, effective upon termination of the agency, the  
6 administrator of the funds or the Insurance Commissioner, whichever is applicable. The Public  
7 Employees Insurance Old Fund and the Assigned Risk Fund are participant plans as defined in  
8 §12-6-2 and are subject to the provisions of §12-6-9a. The funds may be invested by the  
9 Investment Management Board in accordance with said article.

10 (b) If the Governor issues the proclamation set forth in this article, then, effective upon  
11 termination of the agency, all remaining assets and funds contained in the Public Employees Fund  
12 which are payable to the new fund shall be so disbursed and paid to the company in a manner  
13 previously provided by the director to the State Treasurer or other appropriate state official.

**§5-16A-8. Transfer of assets from new fund to the Domestic Mutual Insurance Company**  
**established as a successor to the agency; transfer of agency employees.**

1 (a) If the Governor determines that:

2 (1) The old fund assets are sufficient to satisfy the old fund liabilities or that a revenue  
3 source has been secured to satisfy the old fund liabilities as they occur from time to time;

4 (2) The director has established a Domestic Mutual Insurance Company pursuant to this  
5 code; and

6 (3) The Insurance Commissioner has determined that the Domestic Mutual Insurance  
7 Company established by the director qualifies:

8 (A) For a certificate of authority to transact industrial insurance in this state; and

9           (B) For the authority to issue nonassessable policies of insurance pursuant to this code,  
10 the Governor shall issue a proclamation stating that the events described in subdivisions (1)  
11 through (3), inclusive, of this subsection have occurred, along with the exact amount of funds to be  
12 transferred from the Public Employees Insurance Fund to the old fund. The proclamation may not  
13 be effective any earlier than June 30, 2025.

14           (b) If the Governor issues a proclamation the director shall transfer to the Domestic Mutual  
15 Insurance Company established pursuant to this code the premiums and other money paid or  
16 payable, transferred or transferable from the Public Employee Insurance Fund into the new fund,  
17 old fund, and any other applicable fund. The Investment Management Board, State Treasurer and  
18 any other agency or board shall fully cooperate in the transfer of the new fund assets.

19           (c) Upon the issuance of the proclamation set forth is subsection (a) of this section, all  
20 agency employees assigned regulatory duties shall transfer from the agency to the Public  
21 Employees Insurance Council: *Provided*, That the director has sole authority to identify and select  
22 the employees that are employed by the agency to be assigned and transferred to the Insurance  
23 Commission.

24           (d) All employees not transferred pursuant to the provisions of subsection (c) shall  
25 immediately upon the transfer date become at-will employees of the company.

26           (e) The Division of Personnel shall cooperate fully by assisting in all personnel activities  
27 necessary to expedite all changes for the agency and the Insurance Commissioner. Due to the  
28 emergency currently existing at the agency and the urgent need to develop fast, efficient claims  
29 processing, management and administration, the Insurance Commissioner is granted authority to  
30 reorganize internal functions and operations and to delegate, assign, transfer, combine, establish,  
31 eliminate and consolidate responsibilities and duties to and among the positions transferred under  
32 the authority of this subsection. These actions may not be subject to the grievance process.

**§5-16A-9. Certain personnel provisions governing employees laid-off by the mutual during**  
**its                      initial                      year                      of                      operation.**

1 If a domestic mutual insurance company is established pursuant to this article, a person  
2 who:

3 (1) Is employed on July 1, 2025, by the agency;

4 (2) Was employed by the agency upon its termination; and

5 (3) Is laid off by the company on or before January 1, 2025, is entitled to be placed on an  
6 appropriate reemployment list maintained by the Division of Personnel and to be allowed a  
7 preference on that list. The Division of Personnel shall maintain such employee on the  
8 reemployment list indefinitely, or until the employee has declined three offers of employment at a  
9 paygrade substantially similar to that of his or her position upon termination of the agency, or until  
10 he or she is reemployed by the executive branch of state government, whichever occurs earlier.

**§5-16A-10. Certain retraining benefits to those employees laid-off by the mutual during its**

**first year of operation.**

1 If a domestic mutual insurance company is established pursuant to this article, the chief  
2 executive officer of the company shall enter into an agreement with the Division of Personnel for  
3 the provision of services and training to an employee of the company who is laid off during the first  
4 year of the company's operation and requires additional training to obtain other gainful  
5 employment. The Division of Personnel shall administer the program. The fees required for those  
6 services and training shall be in an amount established by the Division of Personnel, may not  
7 exceed \$3 million, in the aggregate, and shall be paid out of the mutualization transition fund.

**§5-16A-11. Certain benefits provided to commission employees.**

1 (a) If a domestic mutual insurance company is created pursuant to this article and  
2 becomes operational as a private carrier, then the company shall pay the full actuarial cost to  
3 purchase years of credit for not more than five years of service under the state's public employee  
4 retirement system to those individuals who retire upon termination of the agency or who become  
5 employed by the company upon termination of the agency. The amount purchased per employee  
6 shall be calculated by allowing six months of credit to be purchased for each year of service with

7 the agency and shall be paid out of the mutualization transition fund. If upon said purchase, an  
8 employee does not vest in the public employee retirement plan, the employee can receive his or  
9 her contribution from the retirement plan and an amount equal to the employer's contribution to be  
10 payable out of the mutualization transition fund.

11 (b) The public employees' retirement system shall take such action as is necessary to carry  
12 out the provisions of subsection (a).

13 (c) Any employee of the agency as of the transfer date and who becomes an employee of  
14 the company shall have the following options related to their accrued and unused sick leave:  
15 Freeze said accrued and unused sick leave at the balance that exists as of the transfer date and  
16 use said sick leave at the time of retirement for those purposes that would have been available to  
17 the employee under law in existence at the date of the transfer had the employee retired on the  
18 transfer date; or have his or her accrued and unused sick leave irrevocably surrendered in  
19 exchange for one hour of pay for each hour of accrued and unused sick leave surrendered to be  
20 payable from the mutualization transition fund. With respect to any agency employee as of the  
21 transfer date and who becomes an employee of the company, the Department of Administration  
22 shall pay the employee such amounts as the employee is entitled for his or her accrued but  
23 unused annual leave, not to exceed 40 days.

24 (d) The Division of Personnel shall cooperate fully by assisting in all activities necessary to  
25 expedite all changes for the agency and agency employees, including, but not limited to, all of the  
26 above subsections.

**§5-16A-12. Mandatory coverage.**

1 (a) Effective upon termination of the agency, all participant plans for the public employees  
2 of the State of West Virginia shall transfer to the company and all public employees of West  
3 Virginia who choose to utilize public employees insurance shall participate in the plans offered by  
4 the company. The company shall assume responsibility for all new fund obligations.

5 (b) The company shall establish a group hospital and surgical insurance plan or plans, a



group prescription drug insurance plan or plans, a group major medical insurance plan or plans and a group life and accidental death insurance plan or plans for those employees who are eligible and administer these plans subject to the limitations contained in this article. These plans shall include:

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

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

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

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

(5) For plans which provide coverages for post-delivery care to a mother and her newly born child in the home, coverage for inpatient care following childbirth as provided in subdivision (4) of this subsection if inpatient care is determined to be medically necessary by the attending

physician. These plans may include, among other things, medicines, medical equipment, prosthetic appliances and any other inpatient and outpatient services and expenses considered appropriate and desirable by the agency; and

(6) Coverage for treatment of serious mental illness:

(A) The coverage does not include custodial care, residential care or schooling. For purposes of this section, "serious mental illness" means an illness included in the American Psychiatric Association's Diagnostic and Statistical Manual of mental disorders, as periodically revised, under the diagnostic categories or subclassifications of: (i) Schizophrenia and other psychotic disorders; (ii) bipolar disorders; (iii) depressive disorders; (iv) substance-related disorders with the exception of caffeine-related disorders and nicotine-related disorders; (v) anxiety disorders; and (vi) anorexia and bulimia. With regard to a covered individual who has not yet attained the age of 19 years, "serious mental illness" also includes attention deficit hyperactivity disorder, separation anxiety disorder and conduct disorder.

(B) Notwithstanding any other provision in this section to the contrary, if the company demonstrates that its total costs for the treatment of mental illness for any plan exceeds two percent of the total costs for such plan in any experience period, then the company may apply whatever additional cost-containment measures may be necessary in order to maintain costs below two percent of the total costs for the plan for the next experience period. These measures may include, but are not limited to, limitations on inpatient and outpatient benefits.

(C) The company may not discriminate between medical-surgical benefits and mental health benefits in the administration of its plan. With regard to both medical-surgical and mental health benefits, it may make determinations of medical necessity and appropriateness and it may use recognized health care quality and cost management tools including, but not limited to, limitations on inpatient and outpatient benefits, utilization review, implementation of cost-containment measures, preauthorization for certain treatments, setting coverage levels, setting maximum number of visits within certain time periods, using capitated benefit arrangements, using

fee-for-service arrangements, using third-party administrators, using provider networks and using patient cost sharing in the form of copayments, deductibles, and coinsurance.

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

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

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

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

(B) The coverage shall include, but not be limited to, applied behavior analysis which shall be provided or supervised by a certified behavior analyst. The annual maximum benefit for applied behavior analysis required by this subdivision shall be in an amount not to exceed \$30,000 per individual for three consecutive years from the date treatment commences. At the conclusion

of the third year, coverage for applied behavior analysis required by this subdivision shall be in an amount not to exceed \$2,000 per month, until the individual reaches 18 years of age, as long as the treatment is medically necessary and in accordance with a treatment plan developed by a certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual. This subdivision does not limit, replace or affect any obligation to provide services to an individual under the Individuals with Disabilities Education Act, 20 U. S. C. 1400 *et seq.*, as amended from time to time or other publicly funded programs. Nothing in this subdivision requires reimbursement for services provided by public school personnel.

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

- (i) The individual's condition is improving in response to treatment;
- (ii) A maximum improvement is yet to be attained; and
- (iii) There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

(D) To the extent that the application of this subdivision for autism spectrum disorder causes an increase of at least one percent of actual total costs of coverage for the plan year, the agency may apply additional cost containment measures.

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

(9) For plans that include maternity benefits, coverage for the same maternity benefits for all individuals participating in or receiving coverage under plans that are issued or renewed on or after January 1, 2014: *Provided*, That to the extent that the provisions of this subdivision require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient

Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits may not be required of a health benefit plan when the plan is offered in this state.

(10) Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, reimbursement or indemnification for colorectal cancer examinations and laboratory testing may not be denied for any nonsymptomatic person 50 years of age or older, or a symptomatic person under 50 years of age, when reimbursement or indemnity for laboratory or X ray services are covered under the policy and are performed for colorectal cancer screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery by the Board of Medicine. The tests are as follows: An annual fecal occult blood test, a flexible sigmoidoscopy repeated every five years, a colonoscopy repeated every 10 years and a double contrast barium enema repeated every five years.

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

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

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

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

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

(C) Prostheses and physical complications of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient. Coverage shall be provided for a minimum stay in the hospital of not less than 48 hours for a patient following a radical or modified mastectomy and not less than 24 hours of inpatient care following a total mastectomy or partial mastectomy with lymph node dissection for the treatment of breast cancer. Nothing in this section shall be construed as requiring inpatient coverage where inpatient coverage is not medically necessary or where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate. This coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter in the summary plan description or similar document. The plan may not deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

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

(12) Coverage for patient cost of clinical trials.

(A) The provisions of this section apply to the health plans regulated by this article.

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

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

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

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

164 (D) The coverage under paragraph (C) of this section is required if the treatment is being  
165 provided or the studies are being conducted in a Phase II, Phase III or Phase IV clinical trial for  
166 cancer and has therapeutic intent or the treatment is being provided in a Phase II, Phase III, or  
167 Phase IV clinical trial for any other life-threatening condition and has therapeutic intent or, the  
168 treatment is being provided in a clinical trial approved by one of the national institutes of health, an  
169 NIH cooperative group or an NIH center, the FDA in the form of an investigational new drug  
170 application or investigational device exemption, the federal Department of Veterans Affairs or, an  
171 institutional review board of an institution in the state which has a multiple project assurance  
172 contract approved by the office of protection from research risks of the national institutes of health;

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

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

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

178 (iv) The treatment is provided in this state: *Provided*, That, if the treatment is provided  
179 outside of this state, the treatment must be approved by the payor designated in subsection (a) of  
180 this section;

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

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

187 (E) Payment for patient costs for a clinical trial is not required by the provisions of this

188 section, if:

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

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

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

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

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

201 (c) The company shall, with full authorization, make available to each eligible employee, at  
202 full cost to the employee, the opportunity to purchase optional group life and accidental death  
203 insurance as established under the rules of the agency. In addition, each employee is entitled to  
204 have his or her spouse and dependents, as defined by the rules of the agency or by the company,  
205 included in the optional coverage, at full cost to the employee, for each eligible dependent.

206 (d) The company may cause to be separately rated for claims experience purposes:

207 (1) All employees of the state of West Virginia;

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

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

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

213 (e) The company shall maintain the medical and prescription drug coverage for Medicare



214 eligible retirees by providing coverage through one of the existing plans or by enrolling the  
 215 Medicare eligible retired employees into a Medicare specific plan, including, but not limited to, the  
 216 Medicare/Advantage Prescription Drug Plan. If a Medicare specific plan is no longer available or  
 217 advantageous for the agency and the retirees, the retirees remain eligible for coverage through the  
 218 agency.

**§5-16A-13. Permissive participation; exemptions.**

1 (a) The provisions of this article are not mandatory upon any employee or employer who is  
 2 not an employee of or is not the state of West Virginia, its boards, agencies, commissions,  
 3 departments, institutions or spending units or a county board of education, and nothing contained  
 4 in this article may be construed so as to compel any employee or employer to enroll in or subscribe  
 5 to any insurance plan authorized by the provisions of this article.

6 (b) Employees enrolled in the insurance program authorized under the provisions of article  
 7 §21A-2B-1 et seq. of this code may not be required to enroll in or subscribe to an insurance plan or  
 8 plans authorized by the provisions of this article, and the employees of any department which has  
 9 an existing insurance program for its employees to which the government of the United States  
 10 contributes any part or all of the premium or cost of the premium may be exempted from the  
 11 provisions of this article. Any employee or employer exempted under the provisions of this  
 12 paragraph may enroll in any insurance program authorized by the provisions of this article at any  
 13 time, to the same extent as any other qualified employee or employer, but employee or employer  
 14 may not remain enrolled in both programs. The provisions of §33-14-1 et seq., §33-15-1 et seq.,  
 15 and §33-15-1 et seq. relating to group life insurance, accident and sickness insurance, and group  
 16 accident and sickness insurance, are not applicable to this article if §33-14-1 et seq., §33-15-1 et  
 17 seq., and §33-15-1 et seq. are in conflict with or contrary to any provision set forth in this article or  
 18 to any plan or plans established by the company.

19 (c) Employers, other than the state of West Virginia, its boards, agencies, commissions,  
 20 departments, institutions, spending units or a county board of education are exempt from

21 participating in the insurance program provided for by the provisions of this article unless  
22 participation by the employer has been approved by a majority vote of the employer's governing  
23 body. It is the duty of the clerk or secretary of the governing body of an employer who, by majority  
24 vote, becomes a participant in the insurance program to notify the director not later than 10 days  
25 after the vote.

26 (d) Any employer, whether the employer participates in the Public Employees Insurance  
27 Agency insurance program as a group or not, which has retired employees, their dependents or  
28 surviving dependents of deceased retired employees who participate in the Public Employees  
29 Insurance Agency insurance program as authorized by this article, shall pay to the company the  
30 same contribution toward the cost of coverage for its retired employees, their dependents or  
31 surviving dependents of deceased retired employees as the state of West Virginia, its boards,  
32 agencies, commissions, departments, institutions, spending units or a county board of education  
33 pay for their retired employees, their dependents and surviving dependents of deceased retired  
34 employees, as determined by the finance board: *Provided, That after June 30, 1996, an employer*  
35 not mandated to participate in the plan is only required to pay a contribution toward the cost of  
36 coverage for its retired employees, their dependents or the surviving dependents of deceased  
37 retired employees who elect coverage when the retired employee participated in the plan as an  
38 active employee of the employer for at least five years: *Provided, however, That those retired*  
39 employees of an employer not participating in the plan who retire on or after July 1, 2010, who  
40 have participated in the plan as active employees of the employer for less than five years are  
41 responsible for the entire premium cost for coverage and the company shall bill for and collect the  
42 entire premium from the retired employees, unless the employer elects to pay the employer share  
43 of the premium. Each employer is hereby authorized and required to budget for and make such  
44 payments as are required by this section.

45 (e) Any person employed by the State of West Virginia on or before the transfer date may  
46 use their accrued and unused sick leave at the time of retirement for those purposes that would

47 have been available to the employee under law in existence at the date of the transfer had the  
48 employee retired on the transfer date, including use of sick leave at the time of retirement to  
49 purchase insurance through the company.

**§5-16A-14. Administration of old fund.**

1 (a) Notwithstanding any provision of this code to the contrary, the company shall be the  
2 administrator of the old fund from its inception and thereafter for seven years and shall be charged  
3 with all authority and responsibilities incidental to the administration of the old fund which are  
4 necessary to accomplish the express provisions and the intent of this article. The company shall  
5 be paid a monthly administrative fee of five percent of claims paid each month for the  
6 administration of the old fund through June 30, 2028, and four percent of claims paid each month  
7 for the administration of the old fund thereafter through the June 30, 2029. The company's  
8 administrative duties shall include, but not be limited to, receipt of all claims, processing said  
9 claims, providing for the payment of said claims through the State Treasurer's office or other  
10 applicable state agency, and ensuring, through the selection and assignment of counsel, that  
11 claims decisions are properly defended. The administration of the old fund after this seven-year  
12 period shall be subject to the procedures set forth in §5A-31 et seq.

13 (b) The Insurance Commissioner may contract or employ counsel to perform legal services  
14 related solely to the collection of moneys due the old fund and enforcement of repayment  
15 agreements entered into for the collection of moneys due on or before June 30, 2025, in any  
16 administrative proceeding and in any state or federal court.

17 (c) The Insurance Commissioner may conduct or cause to be conducted an annual audit to  
18 be performed on the old fund.

**§5-16A-15. Ratemaking; insurance commissioner.**

1 (a) For the fiscal year beginning July 1, 2026, the company shall charge the actuarially  
2 determined base rates for the fiscal year. The base rates shall be calculated by the company and  
3 submitted for the fiscal year beginning July 1, 2027, all private carriers' rates shall be governed by

4 the following:

5 (1) For the period beginning on July 1, 2025, and ending on June 30, 2026, no more than  
6 five percent variance from the base rates established by the Insurance Commissioner.

7 (2) For the period beginning on July 1, 2026, and ending on June 30, 2027, no more than  
8 ten percent variance from the base rates established by the Insurance Commissioner.

9 (b) The Insurance Commissioner approval by the Insurance Commissioner.

10 (c) For the fiscal year beginning July 1, 2027, the company shall charge the actuarially  
11 determined base rates for said fiscal year. The base rates shall be calculated by the company and  
12 submitted for approval by the Insurance Commissioner.

13 (d) Effective retains authority to disapprove rates in effect if it is determined that the rates  
14 are not in compliance with the following:

15 (1) Rates must not be excessive, inadequate or unfairly discriminatory, nor may an insurer  
16 charge any rate which if continued will have or tend to have the effect of destroying competition or  
17 creating a monopoly.

18 (2) The Insurance Commissioner may disapprove rates if there is not a reasonable degree  
19 of price competition at the consumer level. In determining whether a reasonable degree of price  
20 competition exists, the Insurance Commissioner shall consider all relevant tests, including:

21 (A) The number of insurers actively engaged and their shares of the market;

22 (B) The existence of differentials in rates in that class;

23 (C) Whether long-run profitability for private carriers generally of the class is unreasonably  
24 high in relation to its risk;

25 (D) Consumers' knowledge in regard to the market in question; and

26 (E) Whether price competition is a result of the market or is artificial. If competition does  
27 not exist, rates are excessive if they are likely to produce a long-run profit that is unreasonably high  
28 in relation to the risk of the class of business, or if expenses are unreasonably high in relation to  
29 the services rendered.

(3) Rates are inadequate if they are clearly insufficient, together with the income from investments attributable to them, to sustain projected losses and expenses in the class.

(4) One rate is unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the differences in expected losses and expenses. Rates are not unfairly discriminatory because different premiums result for policyholders with similar exposure to loss but different expense factors, or similar expense factors but different exposure to loss, so long as the rates reflect the differences with reasonable accuracy. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, franchise or blanket policy.

**§5-16A-16. Claims administration issues.**

The successor to the agency and any other private carrier shall exercise all authority and responsibility granted to the agency in this article and provide notices of action taken to effect the purposes of this article to provide health and surgical care benefits as set forth in this article to persons who are plan participants. The successor to the agency and private carriers shall at all times be bound and shall comply fully with all of the provisions of this article.

**§5-16A-17. Rules.**

Except as otherwise provided in this chapter, all rules applicable to the former Public Employees Insurance Agency are hereby adopted and made effective as to the operation of the public employees insurance market to the extent that they are not in conflict with the current law. Authority to enforce the existing rules and the regulatory functions of the agency as set forth in chapter five of the code shall transfer from the agency to the Insurance Commissioner effective upon termination of the agency. The Insurance Commissioner shall review and seek approval, modification or replacement, through the public employees insurance council, of all existing rules no later than July 1, 2025.

**§5-16A-18. Transfer of assets and contracts.**

With the establishment of the company, all agency assets, including, but not limited to, all tangible items, records (electronic and hard copy) necessary to administer the old fund and

3 operate as the company, hardware, software, intellectual property, maintenance agreements,  
4 system support agreements, and warranties, and all contracts, along with rights and obligations  
5 thereunder, obtained or signed on behalf of the Public Employees Insurance Agency in  
6 furtherance of the purposes of this article, are hereby transferred and assigned to the company.

**§5-16A-19. No waiver of sovereign immunity.**

1 Nothing contained in this article may be deemed or construed to waive or abrogate in any  
2 way the sovereign immunity of the state or to deprive the board, department or any officer or  
3 employee thereof of sovereign immunity.

**§5-16A-20. Not obligation of the state.**

1 The obligations of the company may not constitute debts or obligations of the agency, the  
2 Department of Administration or the state.

NOTE: The purpose of this bill is to dissolve the Public Employees Insurance Agency and convert it to an employer-owned mutual insurance company.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added. §5-16-1 and §5-16-2 have been completely rewritten.