WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

ENGROSSED

Committee Substitute

for

House Bill 4965

By Delegates Kimble, Vance, and Mazzocchi

[Originating in the Committee on Health and Human Resources; Reported on March 2, 2026]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding a new section, designated §5-16-7h, relating to patient-centered treatment flexibility with the Public Employees Insurance Agency.

Be it enacted by the Legislature of West Virginia:

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

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

(a) For purposes of this section:

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

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

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

(b) If a patient has received prior authorization from the agency for a covered treatment for a diagnosed condition, the patient may receive an alternative covered treatment for the same condition without requiring a new or additional prior authorization, subject to the requirements of this section. A patient is not eligible to receive the alternative treatment and the original covered treatment at the same time.

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

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

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

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

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

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

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

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

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

(e) The agency may not:

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

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