

# **WEST VIRGINIA LEGISLATURE**

## **2026 REGULAR SESSION**

### **Introduced**

## **House Bill 4965**

**FISCAL  
NOTE**

By Delegates Kimble, Vance, and Mazzocchi

[Introduced January 29, 2026; referred to the  
Committee on Health and Human Resources]

1 A BILL to amend the Code of West Virginia, 1931, as amended, by adding a new section,  
2 designated §5-16-7h, relating to patient-centered treatment flexibility with the Public  
3 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.**

1 (a) For purposes of this section:

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

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

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

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

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

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

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

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

20 (1) A licensed health care provider shall document in the patient's medical record that the

21 alternative treatment is medically appropriate and intended to treat the same diagnosed condition  
22 as the originally authorized treatment.

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

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

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

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

32 (e) The agency may not:

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

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

NOTE: The purpose of this bill is to allow a patient who has received prior authorization from the Public Employees Insurance Agency for treatment of a medical condition to receive an alternative covered treatment for the same condition without additional prior authorization, provided the alternative treatment is medically appropriate and does not exceed the cost of the originally authorized treatment.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.