WEST VIRGINIA LEGISLATURE

2017 REGULAR SESSION

Introduced

Senate Bill 555

FISCAL NOTE

[Introduced March 8, 2017; Referred

to the Committee on Banking and Insurance; and then

to the Committee on Finance]

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

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

Be it enacted by the Legislature of West Virginia:

That §5-16-7e of the Code of West Virginia, 1931, as amended, be repealed; that §5-16-1, §5-16-2, §5-16-3, §5-16-4, §5-16-5, §5-16-7, §5-16-7a, §5-16-7c, §5-16-7d, §5-16-8, §5-16-9, §5-16-10, §5-16-11, §5-16-12, §5-16-12a, §5-16-13, §5-16-15, §5-16-16, §5-16-17, §5-16-18 and §5-16-24 of said code be amended and reenacted; and that said code be amended by adding thereto a new article, designated §5-16A-1, §5-16A-2, §5-16A-3, §5-16A-4, §5-16A-5, §5-16A-6, §5-16A-7, §5-16A-8, §5-16A-9, §5-16A-10, §5-16A-11, §5-16A-12, §5-16A-13, §5-16A-14, §5-16A-15, §5-16A-16, §5-16A-17, §5-16A-18, §5-16A-19 and §5-16A-20, all to read as follows:

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE <u>PRIVITATAZATION</u> ACT.

§5-16-1. Short title.

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

<u>This article shall be referred to as the West Virginia Public Employees Insurance</u>

7 Privatization Act.

§5-16-2. Definitions.

1 As used in this article:

2 (1) "Agency" means the Public Employees Insurance Agency created by this article.

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

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

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

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

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

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

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

24 (6) "Cooperative group" means a formal network of facilities that collaborate on research
25 projects and have an established National Institute of Health (NIH)-approved peer review program

26 operating within the group. A cooperative group includes:

27 (A) The national cancer institute clinical cooperative group;

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

29 (C) The AIDS clinical trial group; and

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

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

32 this article.

33 (8) "Emergency medical condition" means a condition that manifests itself by acute

34 symptoms of sufficient severity including severe pain such that the absence of immediate medical

35 attention could reasonably be expected to result in serious jeopardy to the individual's health or

36 with respect to a pregnant woman the health of the unborn child, serious impairment to bodily

37 functions or serious dysfunction of any bodily part or organ.

38 (9) "Emergency medical condition for the prudent layperson" means one that manifests

39 itself by acute symptoms of sufficient severity, including severe pain, such that the person could

40 reasonably expect the absence of immediate medical attention to result in serious jeopardy to the

41 individual's health, or, with respect to a pregnant woman, the health of the unborn child; serious

42 impairment to bodily functions; or serious dysfunction of any bodily organ or part;

43 (10) "Emergency services" means those services required to screen for or treat an

44 emergency medical condition until the condition is stabilized, including prehospital care;

45 (11) "Employee" means any person, including an elected officer, who works regularly full

46 time in the service of the State of West Virginia and, for the purpose of this article only, the term

47 "employee" also means any person, including an elected officer, who works regularly full time in

48 the service of a county board of education; a county, city or town in the state; any separate

49 corporation or instrumentality established by one or more counties, cities or towns, as permitted

50 by law; any corporation or instrumentality supported in most part by counties, cities or towns; any

51 public corporation charged by law with the performance of a governmental function and whose

52 jurisdiction is coextensive with one or more counties, cities or towns; any comprehensive
53 community mental health center or comprehensive mental retardation facility established,
54 operated or licensed by the Secretary of Health and Human Resources pursuant to section one,
55 article two-a, chapter twenty-seven of this code and which is supported in part by state, county or
56 municipal funds; any person who works regularly full time in the service of the Higher Education
57 Policy Commission, the West Virginia Council for Community and Technical College Education
58 or a governing board, as defined in section two, article one, chapter eighteen-b of this code; any
59 person who works regularly full time in the service of a combined city-county health department
60 created pursuant to article two, chapter sixteen of this code; any person designated as a 21st
61 Century Learner Fellow pursuant to section eleven, article three, chapter eighteen-a of this code;
62 and any person who works as a long-term substitute as defined in section one, article one, chapter
63 eighteen-a of this code in the service of a county board of education: *Provided,* That a long-term
64 substitute who is continuously employed for at least one hundred thirty-three instructional days
65 during an instructional term, and until the end of that instructional term, is eligible for the benefits
66 provided in this article until September 1, following that instructional term: *Provided, however,*
67 That a long-term substitute employed fewer than one hundred thirty-three instructional days
68 during an instructional term is eligible for the benefits provided in this article only during such time
69 as he or she is actually employed as a long-term substitute. On and after January 1, 1994, and
70 upon election by a county board of education to allow elected board members to participate in the
71 Public Employees Insurance Program pursuant to this article, any person elected to a county
72 board of education shall be considered to be an "employee" during the term of office of the elected
73 member. Upon election by the state Board of Education to allow appointed board members to
74 participate in the Public Employees Insurance Program pursuant to this article, any person
75 appointed to the state Board of Education is considered an "employee" during the term of office
76 of the appointed member: *Provided further,* That the elected member of a county board of
77 education and the appointed member of the state Board of Education shall pay the entire cost of

78 the premium if he or she elects to be covered under this article. Any matters of doubt as to who
79 is an employee within the meaning of this article shall be decided by the director.
80 On or after July 1, 1997, a person shall be considered an "employee" if that person meets
81 the following criteria:
82 (i) Participates in a job-sharing arrangement as defined in section one, article one, chapter
83 eighteen-a of this code;
84 (ii) Has been designated, in writing, by all other participants in that job-sharing
85 arrangement as the "employee" for purposes of this section; and
86 (iii) Works at least one third of the time required for a full-time employee.
87 (12) "Employer" means the State of West Virginia, its boards, agencies, commissions,
88 departments, institutions or spending units; a county board of education; a county, city or town in
89 the state; any separate corporation or instrumentality established by one or more counties, cities
90 or towns, as permitted by law; any corporation or instrumentality supported in most part by
91 counties, cities or towns; any public corporation charged by law with the performance of a
92 governmental function and whose jurisdiction is coextensive with one or more counties, cities or
93 towns; any comprehensive community mental health center or comprehensive mental retardation
94 facility established, operated or licensed by the Secretary of Health and Human Resources
95 pursuant to section one, article two-a, chapter twenty-seven of this code and which is supported
96 in part by state, county or municipal funds; a combined city-county health department created
97 pursuant to article two, chapter sixteen of this code; and a corporation meeting the description set
98 forth in section three, article twelve, chapter eighteen-b of this code that is employing a 21st
99 Century Learner Fellow pursuant to section eleven, article three, chapter eighteen of this code
100 but the corporation is not considered an employer with respect to any employee other than a 21st
101 Century Learner Fellow. Any matters of doubt as to who is an "employer" within the meaning of
102 this article shall be decided by the director. The term "employer" does not include within its
103 meaning the National Guard.

104 (13) "FDA" means the federal food and drug administration.

105 (14) "Finance board" means the Public Employees Insurance Agency finance board
106 created by this article.

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

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

114 (17) "Member" means a policyholder, subscriber, insured, certificate holder or a covered
115 dependent of a policyholder, subscriber, insured or certificate holder.

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

120 (19) "NIH" means the national institutes of health.

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

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

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

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

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

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

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

140 (F) Adverse events during treatment are divided into those that reflect the natural history
141 of the disease, or its progression, and those that are unique in the experimental treatment. Costs
142 for the former are the responsibility of the payor as provided in section two of this article, and
143 costs for the later are the responsibility of the sponsor. The sponsor shall hold harmless any
144 payor for any losses and injuries sustained by any member as a result of his or her participation
145 in the clinical trial.

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

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

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

155 (25) "Primary Coverage" means individual or group hospital and surgical insurance

156 coverage or individual or group major medical insurance coverage or group prescription drug
157 coverage in which the spouse or dependent is the named insured or certificate holder. For the
158 purposes of this section, "dependent" includes an eligible employee’s unmarried child or stepchild
159 under the age of twenty-five if that child or stepchild meets the definition of a "qualifying child" or
160 a "qualifying relative" in Section 152 of the Internal Revenue Code. The director may require
161 proof regarding spouse and dependent primary coverage and shall adopt rules governing the
162 nature, discontinuance and resumption of any employee's coverage for his or her spouse and
163 dependents.

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

167 (27) “Retired employee” means an employee of the state who retired after April 29, 1971,
168 and an employee of the Higher Education Policy Commission, the Council for Community and
169 Technical College Education, a state institution of higher education or a county board of education
170 who retires on or after April 21, 1972, and all additional eligible employees who retire on or after
171 the effective date of this article, meet the minimum eligibility requirements for their respective
172 state retirement system and whose last employer immediately prior to retirement under the state
173 retirement system is a participating employer in the state retirement system and in the Public
174 Employees Insurance Agency: *Provided,* That for the purposes of this article, the employees who
175 are not covered by a state retirement system, but who are covered by a state-approved or state-
176 contracted retirement program or a system approved by the director, shall, in the case of
177 education employees, meet the minimum eligibility requirements of the state Teachers Retirement
178 System and in all other cases, meet the minimum eligibility requirements of the Public Employees
179 Retirement System and may participate in the Public Employees Insurance Agency as retired
180 employees upon terms as the director sets by rule as authorized in this article. Employers with
181 employees who are, or who are eligible to become, retired employees under this article shall be

182 mandatory participants in the Retiree Health Benefit Trust Fund created pursuant to article
183 sixteen-d of this chapter. Nonstate employers may opt out of the West Virginia other post-
184 employment benefits plan of the Retiree Health Benefit Trust Fund and elect to not provide
185 benefits under the Public Employees Insurance Agency to retirees of the nonstate employer, but
186 may do so only upon the written certification, under oath, of an authorized officer of the employer
187 that the employer has no employees who are, or who are eligible to become, retired employees
188 and that the employer will defend and hold harmless the Public Employees Insurance Agency
189 from any claim by one of the employer's past, present or future employees for eligibility to
190 participate in the Public Employees Insurance Agency as a retired employee. As a matter of law,
191 the Public Employees Insurance Agency shall not be liable in any respect to provide plan benefits
192 to a retired employee of a nonstate employer which has opted out of the West Virginia other post-
193 employment benefits plan of the Retiree Health Benefit Trust Fund pursuant to this section.
194 (28) "Stabilize" means with respect to an emergency medical condition, to provide medical
195 treatment of the condition necessary to assure, with reasonable medical probability that no
196 medical deterioration of the condition is likely to result from or occur during the transfer of the
197 individual from a facility: *Provided,* That this provision may not be construed to prohibit, limit or
198 otherwise delay the transportation required for a higher level of care than that possible at the
199 treating facility.

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

1 (a) The Public Employees Insurance Agency consists of the director, the Finance Board,
2 the Advisory Board and any employees who may be authorized by law. The director shall be
3 appointed by the Governor, with the advice and consent of the Senate, and serves at the will and
4 pleasure of the Governor. The director shall have at least three years' experience in health or
5 governmental health benefit administration as his or her primary employment duty prior to
6 appointment as director. The director shall receive actual expenses incurred in the performance

7 of official business. The director shall employ any administrative, technical and clerical
8 employees required for the proper administration of the programs provided in this article. The
9 director shall perform the duties that are required of him or her under the provisions of this article
10 and is the Chief Administrative Officer of the Public Employees Insurance Agency. The director
11 may employ a deputy director.

12 (b) Except for the director, his or her personal secretary, the deputy director and the chief
13 financial officer, all positions in the agency shall be included in the classified service of the civil
14 service system pursuant to article six, chapter twenty-nine of this code <u>except as provided in</u>
15 <u>subsection (h) of this section.</u>

16 (c) The director is responsible for the administration and management of the Public
17 Employees Insurance Agency as provided in this article and in connection with his or her
18 responsibility may make all rules necessary to effectuate the provisions of this article. Nothing in
19 section four or five of this article limits the director's ability to manage on a day-to-day basis the
20 group insurance plans required or authorized by this article, including, but not limited to,
21 administrative contracting, studies, analyses and audits, eligibility determinations, utilization
22 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
26 is to 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
30 the calendar year. Financial plans as addressed in section five of this article shall continue to be
31 on a 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/or 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,
49 imaging services and other drivers of the agency's medical rate of inflation;

50 (8) Recommending cutting-edge benefit designs to the Finance Board to drive behavior
51 and control costs for the plans;

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

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

56 (11) Initiating steps by the agency to adjust payment by the agency for the treatment of
57 hospital acquired infections and related events consistent with the payment policies, operational
58 guidelines and implementation timetable established by the Centers of Medicare and Medicaid

59 Services. The agency shall protect employees and retired employees from any adjustment in
60 payment for hospital acquired infections; and
61 (12) Initiating steps by the agency to reduce the number of employees and retired
62 employees who experience avoidable readmissions to a hospital for the same diagnosis related
63 group illness within thirty days of being discharged by a hospital in this state or another state
64 consistent with the payment policies, operational guidelines and implementation timetable
65 established by the Centers of Medicare and Medicaid Services.
66 (f) The director shall issue an annual progress report to the Joint Committee on
67 Government and Finance on the implementation of any reforms initiated pursuant to this section
68 and other initiatives developed by the agency.
69 (g) Perform all of the duties set forth in article sixteen-a of this chapter.
70 (h) Notwithstanding any provision of this code to the contrary, effective July 1, 2018, if the
71 agency has not been terminated or otherwise discontinued, all employees of the agency are
72 exempt and otherwise not under the jurisdiction of the provisions of the statutes and rules of the
73 classified service set forth in article six, chapter twenty-nine of this code and article six-a of said
74 chapter and are afforded no protections, rights or access to procedures set forth in said provisions;
75 instead, all agency employees shall be at-will employees unless said status is altered by an
76 express, written employment contract executed on behalf of the agency and the employee. The
77 agency and its employees also shall be exempt and otherwise not under the jurisdiction of the
78 state personnel board, the Department of Personnel, or any other successor agency and their
79 statutes and rules.

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

1 (a) If the company created in article sixteen-a of this chapter is created and is operational,
2 the Public Employees Insurance Agency Finance Board ~~is continued~~ shall continue and consists

3 of the Secretary of the Department of Administration or his or her designee and ten members
4 appointed by the Governor, with the advice and consent of the Senate, for terms of four years
5 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.
8 (b) (1) Of the ten members appointed by the Governor with advice and consent of the
9 Senate, one member shall represent the interests of education employees, one shall represent
10 the interests of public employees, one shall represent the interests of retired employees, one shall
11 represent the interests of organized labor, one shall represent the interests of a participating
12 political subdivision and five shall be selected from the public at large. The Governor shall appoint
13 the member representing the interests of education employees from a list of three names
14 submitted by the largest organization of education employees in this state. The Governor shall
15 appoint the member representing the interests of organized labor from a list of three names
16 submitted by the state's largest organization representing labor affiliates. The five members
17 appointed from the public shall each have experience in the financing, development or
18 management of employee benefit programs.
19 (2) All appointments shall be selected to represent the different geographical areas within
20 the state and all members shall be residents of West Virginia. No member may be removed from
21 office by the Governor except for official misconduct, incompetence, neglect of duty, neglect of
22 fiduciary duty or other specific responsibility imposed by this article or gross immorality.
23 (c) The Secretary of the Department of Administration shall serve as chair of the finance
24 board, which shall meet at times and places specified by the call of the chair or upon the written
25 request to the chair of at least two members. The Director of the Public Employees Insurance
26 Agency shall serve as staff to the board. Notice of each meeting shall be given in writing to each
27 member by the director at least three days in advance of the meeting. Six members constitute a
28 quorum. The board shall pay each member the same compensation and expense reimbursement

29 that is paid to members of the Legislature for their interim duties for each day or portion of a day
30 engaged in the discharge of official duties.
31 (d) Upon termination of the board and notwithstanding any provisions in this article to the
32 contrary, the director is authorized to assess monthly employee premium contributions and to
33 change the types and levels of costs to employees only in accordance with this subsection. Any
34 assessments or changes in costs imposed pursuant to this subsection shall be implemented by
35 legislative rule proposed by the director for promulgation pursuant to the provisions of article
36 three, chapter twenty-nine-a of this code. Any employee assessments or costs previously
37 authorized by the finance board shall then remain in effect until amended by rule of the director
38 promulgated pursuant to this subsection.
39 (e) If the company set forth in article sixteen-a of this chapter is created and operational
40 then the current agency shall continue to exist through June 30, 2018, at which time all powers
41 and duties to enforce any rules adopted by the agency are transferred to the Insurance
42 Commissioner or any other applicable state agency or division. If the company created in article
43 sixteen-a of this chapter is not created or is not operational then the agency shall retain all powers
44 and duties to enforce the rules adopted by the agency until such time as the company created in
45 article sixteen-a is created and is operational.

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

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

8 demonstrated experience in analysis of large group health insurance plans, to estimate the total
9 financial requirements of the Public Employees Insurance Agency for each fiscal year and to
10 review and render written professional opinions as to financial plans proposed by the finance
11 board. The actuary shall also assist in the development of alternative financing options and
12 perform any other services requested by the finance board or the director. All reasonable fees
13 and expenses for actuarial services shall be paid by the Public Employees Insurance Agency.
14 Any financial plan or modifications to a financial plan approved or proposed by the finance board
15 pursuant to this section shall be submitted to and reviewed by the actuary and may not be finally
16 approved and submitted to the Governor and to the Legislature without the actuary's written
17 professional opinion that the plan may be reasonably expected to generate sufficient revenues to
18 meet all estimated program and administrative costs of the agency, including incurred but
19 unreported claims, for the fiscal year for which the plan is proposed. The actuary's opinion on the
20 financial plan for each fiscal year shall allow for no more than thirty days of accounts payable to
21 be carried over into the next fiscal year. The actuary's opinion for any fiscal year shall not include
22 a requirement for establishment of a reserve fund.
23 (c) All financial plans required by this section shall establish:
24 (1) Maximum levels of reimbursement which the Public Employees Insurance Agency
25 makes to categories of health care providers;
26 (2) Any necessary cost-containment measures for implementation by the director;
27 (3) The levels of premium costs to participating employers; and
28 (4) The types and levels of cost to participating employees and retired employees.
29 The financial plans may provide for different levels of costs based on the insureds' ability
30 to pay. The finance board may establish different levels of costs to retired employees based upon
31 length of employment with a participating employer, ability to pay or other relevant factors. The
32 financial plans may also include optional alternative benefit plans with alternative types and levels
33 of cost. The finance board may develop policies which encourage the use of West Virginia health

34 care providers.

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

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

42 (2) The finance board shall prepare a proposed financial plan designed to generate
43 revenues sufficient to meet all estimated program and administrative costs of the Public
44 Employees Insurance Agency for the fiscal year. The proposed financial plan shall allow for no
45 more than thirty 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
53 be met.

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

57 (4) Any financial plan shall be designed to allow thirty days or less of accounts payable to
58 be carried over into the next fiscal year. For each fiscal year, the Governor shall provide his or
59 her estimate of total revenues to the finance board no later than October 15, of the preceding

60 fiscal year: *Provided,* That, for the prospective financial plans required by this section, the
61 Governor shall estimate the revenues available for each fiscal year of the plans based on the
62 estimated percentage of growth in general fund revenues. The finance board shall submit its
63 final, approved financial plan, after obtaining the necessary actuary's opinion and conducting one
64 or more public hearings in each congressional district, to the Governor and to the Legislature no
65 later than January 1, preceding the fiscal year. The financial plan for a fiscal year becomes
66 effective and shall be implemented by the director on July 1, of the fiscal year. In addition to each
67 final, approved financial plan required under this section, the finance board shall also
68 simultaneously submit financial statements based on generally accepted accounting practices
69 (GAAP) and the final, approved plan restated on an accrual basis of accounting, which shall
70 include allowances for incurred but not reported claims: *Provided, however,* That the financial
71 statements and the accrual-based financial plan restatement shall not affect the approved
72 financial plan.

73 (e) The provisions of chapter twenty-nine-a of this code shall not apply to the preparation,
74 approval and implementation of the financial plans required by this section.

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

81 (g) The prospective financial plans shall be based on the estimated revenues submitted
82 in accordance with subdivision (4), subsection (d) of this section and shall include an average of
83 the projected cost-sharing percentages of premiums and an average of the projected deductibles
84 and copays for the various programs. Beginning in the plan year which commences on July 1,
85 2002, and in each plan year thereafter, until and including the plan year which commences on

86 July 1, 2006, the prospective plans shall include incremental adjustments toward the ultimate level
87 required in this subsection, in the aggregate cost-sharing percentages of premium between
88 employers and employees, including the amounts of any subsidization of retired employee
89 benefits. Effective in the plan year commencing on July 1, 2006, and in each plan year thereafter,
90 the aggregate premium cost-sharing percentages between employers and employees, including
91 the amounts of any subsidization of retired employee benefits, shall be at a level of eighty percent
92 for the employer and twenty percent for employees, except for the employers provided in
93 subsection (d), section eighteen of this article whose premium cost-sharing percentages shall be
94 governed by that subsection. After the submission of the initial prospective plan, the board may
95 not increase costs to the participating employers or change the average of the premiums,
96 deductibles and copays for employees, except in the event of a true emergency as provided in
97 this section: *Provided,* That if the board invokes the emergency provisions, the cost shall be
98 borne between the employers and employees in proportion to the cost-sharing ratio for that plan
99 year: *Provided, however,* That for purposes of this section, "emergency" means that the most
100 recent projections demonstrate that plan expenses will exceed plan revenues by more than one
101 percent in any plan year*: Provided further,* That 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
107 the actuary, expenditures and any other factors affecting the fiscal stability of the plan and may
108 make any additional modifications to the plan necessary to ensure that the total financial
109 requirements of the agency for the current fiscal year are met. The finance board may not
110 increase the types and levels of cost to employees during its quarterly review except in the event
111 of a true emergency.

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

116 (j) Notwithstanding any provision of this code to the contrary on or after July 2017, the
117 finance board shall develop a plan to allow the insurance plans authorized pursuant to this article
118 to be sold and compete on the open insurance market. These plans shall continue to be sold on
119 the open insurance market until such time as the company created in article sixteen-a of this
120 chapter is created. The finance board shall submit an annual report on the financial soundness
121 of continuing to compete on the open insurance market to the Joint Committee on Government
122 and Finance by December 31 each year starting with December 2017. Any insurance plans sold
123 pursuant to the authority of this section shall be subject to oversight of the Insurance Commission.

124 (k) If the company created in article sixteen-a of this chapter is created and operational
125 then the current agency shall continue to exist through June 30, 2018, at which time all powers
126 and duties of to enforce rules are transferred to the insurance commissioner or any other
127 applicable state agency or division. If the company created in article sixteen-a of this chapter is
128 not created or is not operational then the agency shall retain all powers and duties to enforce the
129 rules adopted by the agency until such time as the company created in article sixteen-a is created
130 and is operational.

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

1 (a) The agency or the company created pursuant to article sixteen-a of this chapter shall
2 establish a group hospital and surgical insurance plan or plans, a group prescription drug

3 insurance plan or plans, a group major medical insurance plan or plans and a group life and
4 accidental death insurance plan or plans for those employees herein made eligible and establish
5 and promulgate rules for the administration of these plans subject to the limitations contained in
6 this article. <u>If the company created in article sixteen-a of this chapter is created and operational</u>
7 <u>then the current agency shall continue to exist through June 30, 2018, at which time all powers</u>
8 <u>and duties to enforce rules are transferred to the insurance commissioner or any other applicable</u>
9 <u>state agency or division. If the company created in article sixteen-a of this chapter is not created</u>
10 <u>or is not operational then the agency shall retain all powers and duties to enforce the rules adopted</u>
11 <u>by the agency until such time as the company created in article sixteen-a is created and is</u>
12 <u>operational.</u> These plans shall include:
13 (1) Coverages and benefits for x-ray and laboratory services in connection with
14 mammograms when medically appropriate and consistent with current guidelines from the United
15 States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology,
16 whichever is medically appropriate, and consistent with the current guidelines from either the
17 United States Preventive Services Task Force or The American College of Obstetricians and
18 Gynecologists; and a test for the human papilloma virus (HPV) when medically appropriate and
19 consistent with current guidelines from either the United States Preventive Services Task Force
20 or The American College of Obstetricians and Gynecologists, when performed for cancer
21 screening or diagnostic services on a woman age eighteen or over;
22 (2) Annual checkups for prostate cancer in men age fifty and over;
23 (3) Annual screening for kidney disease as determined to be medically necessary by a
24 physician using any combination of blood
25 pressure testing, urine albumin or urine protein testing and serum creatinine testing as
26 recommended by the National Kidney Foundation;
27 (4) For plans that include maternity benefits, coverage for inpatient care in a duly licensed
28 health care facility for a mother and her newly born infant for the length of time which the attending

29 physician considers medically necessary for the mother or her newly born child. No plan may
30 deny payment for a mother or her newborn child prior to forty-eight hours following a vaginal
31 delivery or prior to ninety-six hours following a caesarean section delivery if the attending
32 physician considers discharge medically inappropriate;

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

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

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

49 (B) Notwithstanding any other provision in this section to the contrary, if the agency <u>or the</u>
50 <u>company created pursuant to article sixteen-a of this chapter</u> demonstrates that its total costs for
51 the treatment of mental illness for any plan exceeds two percent of the total costs for such plan
52 in any experience period, then the agency <u>or the company created pursuant to article sixteen-a</u>
53 <u>of this chapter</u> may apply whatever additional cost-containment measures may be necessary in
54 order to maintain costs below two percent of the total costs for the plan for the next experience

55 period. These measures may include, but are not limited to, limitations on inpatient and outpatient
56 benefits.
57 (C) The agency <u>or the company created pursuant to article sixteen-a of this chapter</u> shall
58 not discriminate between medical-surgical benefits and mental health benefits in the
59 administration of its plan. With regard to both medical-surgical and mental health benefits, it may
60 make determinations of medical necessity and appropriateness and it may use recognized health
61 care quality and cost management tools including, but not limited to, limitations on inpatient and
62 outpatient benefits, utilization review, implementation of cost-containment measures,
63 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.
67 (7) Coverage for general anesthesia for dental procedures and associated outpatient
68 hospital or ambulatory facility charges provided by appropriately licensed health care individuals
69 in conjunction with dental care if the covered person is:
70 (A) Seven years of age or younger or is developmentally disabled and is an individual for
71 whom a successful result cannot be expected from dental care provided under local anesthesia
72 because of a physical, intellectual or other medically compromising condition of the individual and
73 for whom a superior result can be expected from dental care provided under general anesthesia;
74 (B) A child who is twelve years of age or younger with documented phobias or with
75 documented mental illness and with dental needs of such magnitude that treatment should not be
76 delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of
77 teeth or other increased oral or dental morbidity and for whom a successful result cannot be
78 expected from dental care provided under local anesthesia because of such condition and for
79 whom a superior result can be expected from dental care provided under general anesthesia.
80 (8) (A) Any plan issued or renewed on or after January 1, 2012, shall include coverage for

81 diagnosis, evaluation and treatment of autism spectrum disorder in individuals ages eighteen
82 months to eighteen years. To be eligible for coverage and benefits under this subdivision, the
83 individual must be diagnosed with autism spectrum disorder at age eight or younger. Such plan
84 shall provide coverage for treatments that are medically necessary and ordered or prescribed by
85 a licensed physician or licensed psychologist and in accordance with a treatment plan developed
86 from a comprehensive evaluation by a certified behavior analyst for an individual diagnosed with
87 autism spectrum disorder.

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

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

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

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

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

107 (D) On or before January 1 each year, the agency or the company created pursuant to
108 article sixteen-a of this chapter shall file an annual report with the Joint Committee on Government
109 and Finance describing its implementation of the coverage provided pursuant to this subdivision.
110 The report shall include, but not be limited to, the number of individuals in the plan utilizing the
111 coverage required by this subdivision, the fiscal and administrative impact of the implementation
112 and any recommendations the agency may have as to changes in law or policy related to the
113 coverage provided under this subdivision. In addition, the agency or the company created
114 pursuant to article sixteen-a of this chapter shall provide such other information as required by
115 the Joint Committee on Government and Finance as it may request.
116 (E) For purposes of this subdivision, the term:
117 (i) "Applied behavior analysis" means the design, implementation and evaluation of
118 environmental modifications using behavioral stimuli and consequences in order to produce
119 socially significant improvement in human behavior and includes the use of direct observation,
120 measurement and functional analysis of the relationship between environment and behavior.
121 (ii) "Autism spectrum disorder" means any pervasive developmental disorder including
122 autistic disorder, Asperger's Syndrome, Rett Syndrome, childhood disintegrative disorder or
123 Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and
124 Statistical Manual of Mental Disorders of the American Psychiatric Association.
125 (iii) "Certified behavior analyst" means an individual who is certified by the Behavior
126 Analyst Certification Board or certified by a similar nationally recognized organization.
127 (iv) "Objective evidence" means standardized patient assessment instruments, outcome
128 measurements tools or measurable assessments of functional outcome. Use of objective
129 measures at the beginning of treatment, during and after treatment is recommended to quantify
130 progress and support justifications for continued treatment. The tools are not required but their
131 use will enhance the justification for continued treatment.
132 (F) To the extent that the application of this subdivision for autism spectrum disorder

133 causes an increase of at least one percent of actual total costs of coverage for the plan year, the
134 agency may apply additional cost containment measures.
135 (G) To the extent that the provisions of this subdivision require benefits that exceed the
136 essential health benefits specified under section 1302(b) of the Patient Protection and Affordable
137 Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified
138 essential health benefits shall not be required of insurance plans offered by the Public Employees
139 Insurance Agency or the company created pursuant to article sixteen-a of this chapter.
140 (9) For plans that include maternity benefits, coverage for the same maternity benefits for
141 all individuals participating in or receiving coverage under plans that are issued or renewed on or
142 after January 1, 2014: *Provided,* That to the extent that the provisions of this subdivision require
143 benefits that exceed the essential health benefits specified under section 1302(b) of the Patient
144 Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that
145 exceed the specified essential health benefits shall not be required of a health benefit plan when
146 the plan is offered in this state.
147 (b) The agency or the company created pursuant to article sixteen-a of this chapter shall,
148 with full authorization, make available to each eligible employee, at full cost to the employee, the
149 opportunity to purchase optional group life and accidental death insurance as established under
150 the rules of the agency. In addition, each employee is entitled to have his or her spouse and
151 dependents, as defined by the rules of the agency, included in the optional coverage, at full cost
152 to the employee, for each eligible dependent.
153 (c) The finance board or the company created pursuant to article sixteen-a of this chapter
154 may cause to be separately rated for claims experience purposes:
155 (1) All employees of the State of West Virginia;
156 (2) All teaching and professional employees of state public institutions of higher education
157 and county boards of education;
158 (3) All nonteaching employees of the Higher Education Policy Commission, West Virginia

159 Council for Community and Technical College Education and county boards of education; or

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

161 (d) The agency or the company created pursuant to article sixteen-a of this chapter shall

162 maintain the medical and prescription drug coverage for Medicare eligible retirees by providing

163 coverage through one of the existing plans or by enrolling the Medicare eligible retired employees

164 into a Medicare specific plan, including, but not limited to, the Medicare/Advantage Prescription

165 Drug Plan. If a Medicare specific plan is no longer available or advantageous for the agency and

166 the retirees, the retirees remain eligible for coverage through the agency or the company created

167 pursuant to article sixteen-a of this chapter.

168 (e) If the company created in article sixteen-a of this chapter is created and operational

169 any group plan offered by the company shall be required to contain and provide coverage for all

170 of the provisions set forth in this section.

§5-16-7a. Additional mandated benefits; third party reimbursement for colorectal cancer examination and laboratory testing.

1 (a) Notwithstanding any provision of any policy, provision, contract, plan or agreement

2 applicable to this article, reimbursement or indemnification for colorectal cancer examinations and

3 laboratory testing may not be denied for any nonsymptomatic person fifty years of age or older,

4 or a symptomatic person under fifty years of age, when reimbursement or indemnity for laboratory

5 or X ray services are covered under the policy and are performed for colorectal cancer screening

6 or diagnostic purposes at the direction of a person licensed to practice medicine and surgery by

7 the board of Medicine. The tests are as follows: An annual fecal occult blood test, a flexible

8 sigmoidoscopy repeated every five years, a colonoscopy repeated every ten years and a double

9 contrast barium enema repeated every five years.

10 (b) A symptomatic person is defined as: (1) An individual who experiences a change in

11 bowel habits, rectal bleeding or stomach cramps that are persistent; or (2) an individual who poses

12 a higher than average risk for colorectal cancer because he or she has had colorectal cancer or

13 polyps, inflammatory bowel disease, or an immediate family history of such conditions.

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

17 (d) If the company created in article sixteen-a of this chapter is created and operational
18 any group plan offered by the company shall be required to contain and provide coverage for all
19 of the provisions set forth in this section.

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

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

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

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

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

19 thereafter in the summary plan description or similar document.

20 (b) The plan may not:

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

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

23 (2) Penalize or otherwise reduce or limit the reimbursement of an attending provider, or

24 provide incentives (monetary or otherwise) to an attending provider, to induce such provider to

25 provide care to an individual participant or beneficiary in a manner inconsistent with this section.

26 (c) Nothing in this section shall be construed to prevent a health benefit plan policy or a

27 health insurer offering health insurance coverage from negotiating the level and type of

28 reimbursement with a provider for care provided in accordance with this section.

29 (d) The provisions of this section shall be included under any policy, contract or plan

30 delivered after July 1, 2002.

31 (e) If the company created in article sixteen-a of this chapter is created and operational

32 any group plan offered by the company shall be required to contain and provide coverage for all

33 of the provisions set forth in this section.

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

1 (a) The provisions of this section and section seven-e of this article apply to the health

2 plans regulated by this article.

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

4 Social Security Act.

5 (c) A policy, plan or contract subject to this section shall provide coverage for patient cost

6 to a member in a clinical trial, as a result of:

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

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

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

10 (1)(A) The treatment is being provided or the studies are being conducted in a Phase II,

11 Phase III or Phase IV clinical trial for cancer and has therapeutic intent; or

12 (B) The treatment is being provided in a Phase II, Phase III or Phase IV clinical trial for

13 any other life-threatening condition and has therapeutic intent;

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

15 (A) One of the national institutes of health;

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

17 (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)

30 of 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.

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

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

(2) The purpose of the clinical trial is designed to keep a generic version of a drug from 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 article sixteen-a of this chapter 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.

§5-16-8. 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 article sixteen-a of this chapter:

(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 article sixteen-a of this chapter pursuant to the preceding sentence is not

9 subject to the state administrative procedures act in chapter twenty-nine-a of this code;

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

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

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

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

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

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

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

28 (9) To provide "wellness" programs and activities which will include, but not be limited to,
29 benefit plan incentives to discourage tobacco, alcohol and chemical abuse and an educational
30 program to encourage proper diet and exercise. In establishing "wellness" programs, the Division
31 of Vocational Rehabilitation shall cooperate with the ~~Public Employees Insurance~~ agency in
32 establishing statewide wellness programs and the Division of Vocational Rehabilitation shall
33 continue to provide cooperation with the agency in connection with the “wellness” program until
34 the company established in article sixteen-a of this chapter becomes operational. The director of

35 the ~~Public Employees Insurance~~ agency shall contract with county boards of education for the
36 use of facilities, equipment or any service related to that purpose. Boards of education may
37 charge only the cost of janitorial service and increased utilities for the use of the gymnasium and
38 related equipment. The cost of the exercise program shall be paid by county boards of education,
39 the ~~Public Employees Insurance~~ agency, or participating employees, their spouses or
40 dependents. All exercise programs shall be made available to all employees, their spouses or
41 dependents and shall not be limited to employees of county boards of education;
42 (10) To provide a program, to be administered by the director or the company created
43 pursuant to article sixteen-a of this chapter, for a patient audit plan with reimbursement up to a
44 maximum of $1,000 annually, to employees for discovery of health care provider or hospital
45 overcharges when the affected employee brings the overcharge to the attention of the plan. The
46 hospital or health care provider shall certify to the director that it has provided, prior to or
47 simultaneously with the submission of the statement of charges for payments, an itemized
48 statement of the charges to the employee participant for which payment is requested of the plan;
49 (11) To require that all employers give written notice to each covered employee prior to
50 institution of any changes in benefits to employees, and to include appropriate penalty for any
51 employer not providing the required information to any employee; and
52 (12) (a) To provide coverage for emergency services under offered plans. For the
53 purposes of this subsection, "emergency services" means services provided in or by a hospital
54 emergency facility, an ambulance providing related services under the provisions of article four-
55 c, chapter sixteen of this code or the private office of a dentist to evaluate and treat a medical
56 condition manifesting itself by the sudden, and at the time, unexpected onset of symptoms that
57 require immediate medical attention and for which failure to provide medical attention would result
58 in serious impairment to bodily function, serious dysfunction to any bodily organ or part, or would
59 place the person’s health in jeopardy.
60 (b) From July 1, 1998, plans shall provide coverage for emergency services, including any

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

74 ~~(c) For purposes of this subdivision:~~

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

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

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

85 ~~(D) "Stabilize" means with respect to an emergency medical condition, to provide medical~~
86 ~~treatment of the condition necessary to assure, with reasonable medical probability that no~~

87 ~~medical deterioration of the condition is likely to result from or occur during the transfer of the~~
88 ~~individual from a facility: *Provided,* That this provision may not be construed to prohibit, limit or~~
89 ~~otherwise delay the transportation required for a higher level of care than that possible at the~~
90 ~~treating facility;~~
91 ~~(E) "Medical screening examination" means an appropriate examination within the~~
92 ~~capability of the hospital's emergency department, including ancillary services routinely available~~
93 ~~to the emergency department, to determine whether or not an emergency medical condition~~
94 ~~exists; and~~
95 ~~(F) "Emergency medical condition" means a condition that manifests itself by acute~~
96 ~~symptoms of sufficient severity including severe pain such that the absence of immediate medical~~
97 ~~attention could reasonably be expected to result in serious jeopardy to the individual's health or~~
98 ~~with respect to a pregnant woman the health of the unborn child, serious impairment to bodily~~
99 ~~functions or serious dysfunction of any bodily part or organ.~~

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

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

9 state.

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

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

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

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

25 (4) A checkup for prostate cancer annually for men age fifty or over; and

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

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

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

35 individual and for whom a superior result can be expected from dental care provided under
36 general anesthesia; or
37 (B) A child who is twelve years of age or younger with documented phobias, or with
38 documented mental illness, and with dental needs of such magnitude that treatment should not
39 be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss
40 of teeth or other increased oral or dental morbidity and for whom a successful result cannot be
41 expected from dental care provided under local anesthesia because of such condition and for
42 whom a superior result can be expected from dental care provided under general anesthesia.
43 (c) The group life and accidental death insurance herein provided shall be in the amount
44 of $10,000 for every employee. The amount of the group life and accidental death insurance to
45 which an employee would otherwise be entitled shall be reduced to $5,000 upon such employee
46 attaining age sixty-five.
47 (d) All of the insurance coverage to be provided for under this article may be included in
48 one or more similar contracts issued by the same or different carriers.
49 (e) The provisions of article three, chapter five-a of this code, relating to the Division of
50 Purchasing of the Department of Finance and Administration, shall not apply to any contracts for
51 any insurance coverage or professional services authorized to be executed under the provisions
52 of this article. Before entering into any contract for any insurance coverage, as authorized in this
53 article, the director shall invite competent bids from all qualified and licensed insurance companies
54 or carriers, who may wish to offer plans for the insurance coverage desired: *Provided,* That the
55 director shall negotiate and contract directly with health care providers and other entities,
56 organizations and vendors in order to secure competitive premiums, prices and other financial
57 advantages. The director shall deal directly with insurers or health care providers and other
58 entities, organizations and vendors in presenting specifications and receiving quotations for bid
59 purposes. No commission or finder's fee, or any combination thereof, shall be paid to any
60 individual or agent; but this shall not preclude an underwriting insurance company or companies,

61 at their own expense, from appointing a licensed resident agent, within this state, to service the
62 companies' contracts awarded under the provisions of this article. Commissions reasonably
63 related to actual service rendered for the agent or agents may be paid by the underwriting
64 company or companies: *Provided, however,* That in no event shall payment be made to any
65 agent or agents when no actual services are rendered or performed. The director shall award the
66 contract or contracts on a competitive basis. In awarding the contract or contracts the director
67 shall take into account the experience of the offering agency, corporation, insurance company or
68 service organization in the group hospital and surgical insurance field, group major medical
69 insurance field, group prescription drug field and group life and accidental death insurance field,
70 and its facilities for the handling of claims. In evaluating these factors, the director may employ
71 the services of impartial, professional insurance analysts or actuaries or both. Any contract
72 executed by the director with a selected carrier shall be a contract to govern all eligible employees
73 subject to the provisions of this article. Nothing contained in this article shall prohibit any
74 insurance carrier from soliciting employees covered hereunder to purchase additional hospital
75 and surgical, major medical or life and accidental death insurance coverage.

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

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

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

(i) The director shall provide by contract or contracts entered into under the provisions of this article the cost for coverage of children's immunization services from birth through age sixteen years to provide immunization against the following illnesses: Diphtheria, polio, mumps, measles, rubella, tetanus, hepatitis-b, haemophilus influenzae-b and whooping cough. Additional immunizations may be required by the Commissioner of the Bureau for Public Health for public health purposes. 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/or 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 and/or copayment provisions.

§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.

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

In the event the ~~Public Employees Insurance~~ agency provides the above benefits for retired employees, their spouses and dependents, the ~~Public Employees Insurance~~ agency shall adopt rules ~~and regulations~~ prescribing the conditions under which retired employees may elect to participate in or withdraw from the plan or plans. Any contract or contracts herein provided for shall be secondary to any hospital, surgical, major medical, prescription drug or other health 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 plans, is also eligible to participate in the state Medicaid program, and chooses to do so, then the ~~Public Employees Insurance~~ 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 employee insurance agency's plans.

§5-16-11. To whom benefits paid.

Any benefits payable under any group hospital and surgical, group major medical and group prescription drug plan or plans may be paid either directly to the attending physician, 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 article sixteen-a of this chapter.

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

(a) It shall be 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 article sixteen-a of the chapter;

(5) Willfully overcharge for services provided; or

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

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

(b) If, after notice and an administrative proceeding, it is determined the person has violated the article, the person is liable for any overpayment received. The director or the company created pursuant to article sixteen-a of the chapter shall withhold and set off any payment of any benefits or other payment due to that person until any overpayment is recovered.

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

(d) Any person who violates any provision of this article which results in a loss to, or overpayment from, the plan, or to the State of West Virginia of less than $1,000, and for which no other penalty is specifically provided, is guilty of a misdemeanor and, upon conviction thereof, is subject to a fine of not less than $100 but not more than $500, or imprisonment for a period of not less than twenty-four hours but not more than fifteen days, or both. Any person who violates any provision of this article which results in a loss to, or overpayment from, the plan or the State of West Virginia of $1,000 or more, and for which no other penalty is specifically provided, is guilty of a felony and, upon conviction thereof, is subject to a fine of not less than $1,000 but not more than $5,000, or imprisonment for a period of not less than one nor more than five years, or both.

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

(a) Employers and employees participating in any of the ~~Public Employees Insurance~~

agency plans shall provide, to the director or the company created pursuant to article sixteen-a of this chapter, upon request, all documentation reasonably required for the director or the company created pursuant to article sixteen-a of this chapter to discharge the responsibilities under this article. This documentation includes, but is not limited to, employment or eligibility records sufficient to verify actual full-time employment and eligibility of employees who participate in the ~~Public Employees Insurance~~ agency plans.

(b) Upon a determination of the director or his or her designated representative, or the company created pursuant to article sixteen-a of this chapter that there is probable cause to believe that fraud, abuse or other illegal activities involving transactions with the agency has occurred, the director or his or her designated representative, or the company created pursuant to article sixteen-a of this chapter is authorized to refer the alleged violations to the Insurance Commissioner for investigation and, if appropriate, prosecution, pursuant to article forty-one, chapter thirty-three of this code. For purposes of this section, “transactions with the agency” includes, but is not limited to, application by any insured or dependent, any employer or any type of health care provider for payment to be made to that person or any third party by the agency.

(c) The ~~Public Employees Insurance~~ agency is authorized through administrative proceeding to recover any benefits or claims paid to or for any employee, or their dependents, who obtained or received benefits through fraud. The ~~Public Employees Insurance~~ agency is also authorized through administrative proceeding to recover any funds due from an employer that knowingly allowed or provided benefits or claims to be fraudulently paid to 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 article sixteen-a of this chapter 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.

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

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

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

49 (e) Only authorized employees or agents shall have access to confidential data or systems
50 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 article sixteen-a of this chapter shall provide under any contract or contracts entered into under the provisions of this article or article sixteen-a of this chapter, that the costs of any group hospital and surgical insurance, group major medical insurance, group prescription drug insurance, group life and accidental death insurance benefit plan or plans shall be paid by the employer and employee.

(b) *Spouse and dependent coverage.* -- Each employee is entitled to have his or her spouse and dependents included in any group hospital and surgical insurance, group major medical insurance or group prescription drug insurance coverage to which the employee is entitled to participate: *Provided,* That 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. ~~For purposes of this section, the term "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 twenty-five 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~~

(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

24 for the coverage. An employee discharged for misconduct shall not be eligible for extended
25 benefits under this section. Coverage may be extended up to the maximum period of three
26 months, while administrative remedies contesting the charge of misconduct are pursued. If the
27 discharge for misconduct be upheld, the full cost of the extended coverage shall be reimbursed
28 by the employee. If the employee is again employed or recalled to active employment within
29 twelve months of his or her prior termination, he or she shall not be considered a new enrollee
30 and may not be required to again contribute his or her share of the premium cost, if he or she had
31 already fully contributed such share during the prior period of employment.

32 (d) *Conversion of accrued annual and sick leave for extended insurance coverage upon*
33 *retirement for employees who elected to participate in the plan before July, 1988.* -- Except as
34 otherwise provided in subsection (g) of this section, when an employee participating in the plan,
35 who elected to participate in the plan before July 1, 1988, is compelled or required by law to retire
36 before reaching the age of sixty-five, or when a participating employee voluntarily retires as
37 provided by law, that employee's accrued annual leave and sick leave, if any, shall be credited
38 toward an extension of the insurance coverage provided by this article, according to the following
39 formulae: The insurance coverage for a retired employee shall continue one additional month for
40 every two days of annual leave or sick leave, or both, which the employee had accrued as of the
41 effective date of his or her retirement. For a retired employee, his or her spouse and dependents,
42 the insurance coverage shall continue one additional month for every three days of annual leave
43 or sick leave, or both, which the employee had accrued as of the effective date of his or her
44 retirement.

45 (e) *Conversion of accrued annual and sick leave for extended insurance coverage upon*
46 *retirement for employees who elected to participate in the plan after June, 1988.* --
47 Notwithstanding subsection (d) of this section, and except as otherwise provided in subsections
48 (g) and (l) of this section, when an employee participating in the plan who elected to participate
49 in the plan on and after July 1, 1988, is compelled or required by law to retire before reaching the

50 age of sixty-five, or when the participating employee voluntarily retires as provided by law, that
51 employee's annual leave or sick leave, if any, shall be credited toward one half of the premium
52 cost of the insurance provided by this article, for periods and scope of coverage determined
53 according to the following formulae: (1) One additional month of single retiree coverage for every
54 two days of annual leave or sick leave, or both, which the employee had accrued as of the
55 effective date of his or her retirement; or (2) one additional month of coverage for a retiree, his or
56 her spouse and dependents for every three days of annual leave or sick leave, or both, which the
57 employee had accrued as of the effective date of his or her retirement. The remaining premium
58 cost shall be borne by the retired employee if he or she elects the coverage. For purposes of this
59 subsection, an employee who has been a participant under spouse or dependent coverage and
60 who reenters the plan within twelve months after termination of his or her prior coverage shall be
61 considered to have elected to participate in the plan as of the date of commencement of the prior
62 coverage. For purposes of this subsection, an employee shall not be considered a new employee
63 after returning from extended authorized leave on or after July 1, 1988.

64 (f) *Increased retirement benefits for retired employees with accrued annual and sick leave.*
65 -- In the alternative to the extension of insurance coverage through premium payment provided in
66 subsections (d) and (e) of this section, the accrued annual leave and sick leave of an employee
67 participating in the plan may be applied, on the basis of two days' retirement service credit for
68 each one day of accrued annual and sick leave, toward an increase in the employee's retirement
69 benefits with those days constituting additional credited service in computation of the benefits
70 under any state retirement system: *Provided,* That for a person who first becomes a member of
71 the Teachers Retirement System as provided in article seven-a, chapter eighteen of this code on
72 or after July 1, 2015, accrued annual and sick leave of an employee participating in the plan may
73 not be applied for retirement service credit. However, the additional credited service shall not be
74 used in meeting initial eligibility for retirement criteria, but only as additional service credited in
75 excess thereof.

76 (g) *Conversion of accrued annual and sick leave for extended insurance coverage upon*
77 *retirement for certain higher education employees.* – Except as otherwise provided in subsection
78 (l) of this section, when an employee, who is a higher education full-time faculty member
79 employed on an annual contract basis other than for twelve months, is compelled or required by
80 law to retire before reaching the age of sixty-five, or when such a participating employee
81 voluntarily retires as provided by law, that employee's insurance coverage, as provided by this
82 article, shall be extended according to the following formulae: The insurance coverage for a retired
83 higher education full-time faculty member, formerly employed on an annual contract basis other
84 than for twelve months, shall continue beyond the effective date of his or her retirement one
85 additional year for each three and one-third years of teaching service, as determined by uniform
86 guidelines established by the University of West Virginia Board of Trustees and the board of
87 directors of the state college system, for individual coverage, or one additional year for each five
88 years of teaching service for family coverage.

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

93 (i) *Retiree participation.* -- All retirees under the provisions of this article, including those
94 defined in section two of this article; those retiring prior to April 21, 1972; and those hereafter
95 retiring are eligible to obtain health insurance coverage. The retired employee's premium
96 contribution for the coverage shall be established by the finance board.

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

102 board shall establish the premium cost of the coverage.

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

111 (l) *Participation of certain former employees*. -- An employee, eligible for coverage under
112 the provisions of this article who has twenty years of service with any agency or entity participating
113 in the public employees insurance program or who has been covered by the public employees
114 insurance program for twenty years may, upon leaving employment with a participating agency
115 or entity, continue to be covered by the program if the employee pays one hundred five percent
116 of the cost of retiree coverage: *Provided,* That the employee shall elect to continue coverage
117 under this subsection within two years of the date the employment with a participating agency or
118 entity is terminated.

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

plan upon his or her reemployment.

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

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

(a) ~~On and after July 1, 1989~~ The director or the company created pursuant to article sixteen-a of this chapter shall make available to participants in the public employees insurance system: (1) A dental insurance plan; (2) an optical insurance plan; (3) a disability insurance plan; (4) a prepaid retirement insurance plan; and (5) an audiology and hearing-aid services insurance plan. Public employees insurance participants may elect to participate in any one of these plans separately or in combination. All actuarial and administrative costs of each plan shall be totally borne by the premium payments of the participants or local governing bodies electing to participate in that plan. The director or the company created pursuant to article sixteen-a of this chapter is authorized to employ such administrative practices and procedures with respect to these optional plans as are authorized for the administration of other plans under this article. The director or the company created pursuant to article sixteen-a of this chapter shall establish separate funds: (1) For deposit of dental insurance premiums and payment of dental insurance claims; (2) for deposit of optical insurance premium payments and payment of optical insurance claims; (3) for deposit of disability insurance premium payments and payment of disability insurance claims; and (4) for deposit of audiology and hearing-aid service insurance premiums and payment of audiology and hearing-aid insurance claims. Such funds shall not be supplemented by nor be used to supplement any other funds.

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

20 participants.

§5-16-16. Preferred provider plan.

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

6 The director or the company created pursuant to article sixteen-a of this chapter shall
7 establish the terms of the preferred provider system and the incentives therefor. The terms and
8 incentives may include multiyear renewal options as are not prohibited by the Constitution of this
9 state and capitated primary care arrangements which are not subject to the provisions of article
10 twenty-five-a of chapter thirty-three of this 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 or the company created pursuant to article sixteen-a of

4 this chapter to current and retired employees of the employer as a separate line item, titled "PEIA",
5 in its respective annual budget and are responsible for the transfer of funds to the director or the
6 company created pursuant to article sixteen-a of this chapter for the cost of insurance for
7 employees covered by the plan. Each spending unit shall pay to the director or the company
8 created pursuant to article sixteen-a of this chapter its proportionate share from each source of
9 funds. Any agency wishing to charge General Revenue Funds for insurance benefits for retirees
10 under section thirteen of this article shall provide documentation to the director or the company
11 created pursuant to article sixteen-a of this chapter that the benefits cannot be paid for by any
12 special revenue account or that the retiring employee has been paid solely with General Revenue
13 Funds for twelve months prior to retirement.

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

25 (c) All other employers not operating from the state General Revenue Fund shall pay to
26 the director or the company created pursuant to article sixteen-a of this chapter their share of
27 premium costs from their respective budgets. The finance board or the company created
28 pursuant to article sixteen-a of this chapter shall establish the employers' share of premium costs
29 to reflect and pay the actual costs of the coverage including incurred but not reported claims.

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

42 (e) The employee's proportionate share of the premium or cost shall be withheld or
43 deducted by the employer from the employee's salary or wages as and when paid and the sums
44 shall be forwarded to the director <ins>or the company created pursuant to article sixteen-a of this</ins>
45 <ins>chapter</ins> with any supporting data as the director may require.

46 (f) All moneys received by the ~~Public Employees Insurance~~ agency shall be deposited in
47 a special fund or funds as are necessary in the state Treasury and the Treasurer of the state is
48 custodian of the fund or funds and shall administer the fund or funds in accordance with the
49 provisions of this article or as the director may from time to time direct. The Treasurer shall pay
50 all warrants issued by the State Auditor against the fund or funds as the director may direct in
51 accordance with the provisions of this article. All funds received by the agency, including, but not
52 limited to, basic insurance premiums, administrative expenses and optional life insurance
53 premiums, shall be deposited, as determined by the director, in any of the investment pools with
54 the West Virginia Investment Management Board, including, but not limited to, the equity and
55 fixed income pools, with the interest income or other earnings a proper credit to all such funds for

the benefit of the ~~Public Employees Insurance~~ agency.

(g) The ~~Public Employees Insurance~~ agency or the company created pursuant to article sixteen-a of this chapter 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 article sixteen-d of this chapter, which is due and payable to the ~~Public Employees Insurance~~ agency or the Retiree Health Benefit Trust. The agency or the company created pursuant to article sixteen-a of this chapter may recover the amount due plus an additional amount equal to two and one half percent per annum of the amount due. Accrual of interest owed by the delinquent employer commences upon the thirty-first day following the due date for the amount owed and shall continue until receipt by the ~~Public Employees Insurance~~ agency or the company created pursuant to article sixteen-a of this chapter of the delinquent payment. Interest shall compound every thirty 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 article sixteen-a of this chapter.

§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 and all hearings held by the ~~Public Employees Insurance~~ 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

9 public employees' health insurance program at the premium contribution established by the
10 finance board after any extended coverage to which he or she, his or her spouse and dependents
11 may be entitled by virtue of his or her accrued annual leave or sick leave, pursuant to the
12 provisions of section thirteen of this article, has expired. Any employee who voluntarily retires,
13 as provided by law, is eligible to participate in the public employees' health insurance program at
14 the premium contribution established by the finance board after any extended coverage to which
15 he or she, his or her spouse and dependents may be entitled by virtue of his or her accrued annual
16 leave or sick leave, pursuant to the provisions of section thirteen of this article, has expired:
17 *Provided,* That the employee's last employer is a participating employer. The dependents of any
18 deceased retired employee are entitled to continue their participation and coverage upon payment
19 of the premium contribution established by the finance board or the company created pursuant to
20 article sixteen-a of this chapter. In establishing the cost of health insurance coverage for retired
21 employees and their spouses and dependents, the finance board or the company created
22 pursuant to article sixteen-a of this chapter, in its discretion, may cause the claims experience of
23 the retired employees and their spouses and dependents to be rated separately from that of active
24 employees and their spouses and dependents, or may cause the claims experience of retired and
25 active employees, and their spouses and dependents, to be rated together.

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

34 (d) Any retiree is eligible to participate in the public employees' life insurance program,

35 including the optional life insurance coverage as already available to active employees under this
36 article, at his or her own expense for the cost of coverage, based upon actuarial experience; and
37 the director shall prepare, by rule, for that participation and coverages under declining term
38 insurance and optional additional coverage for the retirees.

39 (e) If the company created in article sixteen-a of this chapter is created and operational
40 then the current agency shall continue to exist through June 30, 2018, at which time all powers
41 and duties to enforce any rules adopted by the agency are transferred to the Insurance
42 Commissioner or any other applicable state agency or division. If the company created in article
43 sixteen-a of this chapter is not created or is not operational then the agency shall retain all powers
44 and duties to enforce the rules adopted by the agency until such time as the company created in
45 article sixteen-a is created and is 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
5 to 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
16 of 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 (1) "Agency" means the Public Employees Insurance Agency created by this article.

4 (2) "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 (3) "Autism spectrum disorder" means any pervasive developmental disorder including
9 autistic disorder, Asperger's Syndrome, Rett Syndrome, childhood disintegrative disorder or
10 Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and
11 Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

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

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

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

22 Phase IV: After the drug, treatment or medical procedure is marketed, investigators

23 continue testing to determine the effects on various populations and to determine whether there
24 are side effects associated with long-term use.
25 (6) “Company” or “successor to the agency” means the Public Employees Mutual
26 Insurance Company created pursuant to the terms of this article.
27 (7) “Cooperative group” means a formal network of facilities that collaborate on research
28 projects and have an established NIH-approved peer review program operating within the group.
29 A cooperative group includes:
30 (A) The national cancer institute clinical cooperative group;
31 (B) The national cancer institute community clinical oncology program;
32 (C) The AIDS clinical trial group; and
33 (D) The community programs for clinical research in AIDS.
34 (8) “FDA” means the federal food and drug administration.
35 (9) “Director” means the Director of the Public Employees Insurance Agency created by
36 this article.
37 (10) "Emergency medical condition" means a condition that manifests itself by acute
38 symptoms of sufficient severity including severe pain such that the absence of immediate medical
39 attention could reasonably be expected to result in serious jeopardy to the individual’s health or
40 with respect to a pregnant woman the health of the unborn child, serious impairment to bodily
41 functions or serious dysfunction of any bodily part or organ.
42 (11) "Emergency medical condition for the prudent layperson" means one that manifests
43 itself 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 (12) "Emergency services" means those services required to screen for or treat an
48 emergency medical condition until the condition is stabilized, including prehospital care;

49 (13) "Employee" means any person, including an elected officer, who works regularly full
50 time in 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
54 by 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,
58 operated or licensed by the Secretary of Health and Human Resources pursuant to section one,
59 article two-a, chapter twenty-seven of this code and which is supported in part by state, county or
60 municipal funds; any person who works regularly full time in the service of the Higher Education
61 Policy Commission, the West Virginia Council for Community and Technical College Education
62 or a governing board, as defined in section two, article one, chapter eighteen-b of this code; any
63 person who works regularly full time in the service of a combined city-county health department
64 created pursuant to article two, chapter sixteen of this code; any person designated as a 21st
65 Century Learner Fellow pursuant to section eleven, article three, chapter eighteen-a of this code;
66 and any person who works as a long-term substitute as defined in section one, article one, chapter
67 eighteen-a of this code in the service of a county board of education: *Provided,* That a long-term
68 substitute who is continuously employed for at least one hundred thirty-three instructional days
69 during an instructional term, and until the end of that instructional term, is eligible for the benefits
70 provided in this article until September 1, following that instructional term: *Provided, however,*
71 That a long-term substitute employed fewer than one hundred thirty-three instructional days
72 during an instructional term is eligible for the benefits provided in this article only during such time
73 as he or she is actually employed as a long-term substitute. On and after January 1, 1994, and
74 upon election by a county board of education to allow elected board members to participate in the

75 Public Employees Insurance Program pursuant to this article, any person elected to a county
76 board of education shall be considered to be an "employee" during the term of office of the elected
77 member. Upon election by the state Board of Education to allow appointed board members to
78 participate in the Public Employees Insurance Program pursuant to this article, any person
79 appointed to the state Board of Education is considered an "employee" during the term of office
80 of the appointed member: *Provided further,* That the elected member of a county board of
81 education and the appointed member of the state Board of Education shall pay the entire cost of
82 the premium if he or she elects to be covered under this article. Any matters of doubt as to who
83 is an employee within the meaning of this article shall be decided by the director.

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

85 (i) Participates in a job-sharing arrangement as defined in section one, article one, chapter
86 eighteen-a of this code;

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

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

90 (14) "Employer" means the State of West Virginia, its boards, agencies, commissions,
91 departments, institutions or spending units; a county board of education; a county, city or town in
92 the state; any separate corporation or instrumentality established by one or more counties, cities
93 or towns, as permitted by law; any corporation or instrumentality supported in most part by
94 counties, cities or towns; any public corporation charged by law with the performance of a
95 governmental function and whose jurisdiction is coextensive with one or more counties, cities or
96 towns; any comprehensive community mental health center or comprehensive mental retardation
97 facility established, operated or licensed by the Secretary of Health and Human Resources
98 pursuant to section one, article two-a, chapter twenty-seven of this code and which is supported
99 in part by state, county or municipal funds; a combined city-county health department created
100 pursuant to article two, chapter sixteen of this code; and a corporation meeting the description set

101 forth in section three, article twelve, chapter eighteen-b of this code that is employing a 21st
102 Century Learner Fellow pursuant to section eleven, article three, chapter eighteen of this code
103 but the corporation is not considered an employer with respect to any employee other than a 21st
104 Century Learner Fellow. Any matters of doubt as to who is an "employer" within the meaning of
105 this article shall be decided by the director. The term "employer" does not include within its
106 meaning the National Guard.

107 (15) "Finance board" means the Public Employees Insurance Agency finance board
108 created by this article.

109 (16) "Insurance Commissioner" means the Insurance Commissioner of West Virginia as
110 provided in section one, article two, chapter, thirty-three of this code.

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

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

118 (19) "Member" means a policyholder, subscriber, insured, certificate holder or a covered
119 dependent of a policyholder, subscriber, insured or certificate holder.

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

124 (21) "Mutualization transition fund" means a fund over which the State Treasurer is
125 custodian. Moneys transferred or otherwise payable to the Mutualization Transition Fund shall
126 be deposited in the State Treasury to the credit of the Mutualization Transition Fund.

127 Disbursements shall be made from the Mutualization Transition Fund upon requisitions signed by
128 the director, and, upon termination of the agency, the Insurance Commissioner, and shall be
129 reasonably related to the legal, operational, consultative and human resource related expenses
130 associated with the establishment of the company and the transferring of personnel from the
131 agency to the company.

132 (22) "NIH" means the national institutes of health.

133 (j) "New fund" means a fund owned and operated by the agency and, upon termination of
134 the agency, the successor organization of the West Virginia Public Employees Insurance Agency
135 and shall consist of those funds transferred to it from the Public Employees Insurance Fund and
136 any other applicable funds. New fund shall include all moneys due and payable to the Public
137 Employee's Insurance Agency as of June 30, 2018.

138 (23) "New fund liabilities" shall mean all claims payment obligations (indemnity and
139 medical expenses) for all claims, actual and incurred but not reported, for any claim with a date
140 of injury or last exposure on or after July 1, 2018.

141 (24) "Old fund" shall mean a fund held by the state treasurer's office consisting of those
142 funds transferred to it from the Public Employees Agency Fund or other sources and those funds
143 due and owing the Public Employees Insurance Fund as of June 30, 2018, that are thereafter
144 collected. The old fund and assets therein shall remain property of the state and shall not novate
145 or otherwise transfer to the company.

146 (25) "Old fund liabilities" mean all claims payment obligations (indemnity and medical
147 expenses), related liabilities and appropriate administrative expenses necessary for the
148 administration of all claims, actual and incurred but not reported, for any claim with a date of injury
149 or last exposure on or before June 30, 2018.

150 (26) "Objective evidence" means standardized patient assessment instruments, outcome
151 measurements tools or measurable assessments of functional outcome. Use of objective
152 measures at the beginning of treatment, during and after treatment is recommended to quantify

153 progress and support justifications for continued treatment. The tools are not required but their
154 use will enhance the justification for continued treatment.
155 (27) “Patient cost” means the routine costs of a medically necessary health care service
156 that is incurred by a member as a result of the treatment being provided pursuant to the protocols
157 of the clinical trial. Routine costs of a clinical trial include all items or services that are otherwise
158 generally available to beneficiaries of the insurance policies. “Patient cost” does not include:
159 (A) The cost of the investigational drug or device;
160 (B) The cost of nonhealth care services that a patient may be required to receive as a
161 result of the treatment being provided to the member for purposes of the clinical trial;
162 (C) Services customarily provided by the research sponsor free of charge for any
163 participant in the trial;
164 (D) Costs associated with managing the research associated with the clinical trial
165 including, but not limited to, services furnished to satisfy data collection and analysis needs that
166 are not used in the direct clinical management of the participant; or
167 (E) Costs that would not be covered under the participant’s policy, plan, or contract for
168 noninvestigational treatments;
169 (F) Adverse events during treatment are divided into those that reflect the natural history
170 of the disease, or its progression, and those that are unique in the experimental treatment. Costs
171 for the former are the responsibility of the payor as provided in section two of this article, and
172 costs for the later are the responsibility of the sponsor. The sponsor shall hold harmless any
173 payor for any losses and injuries sustained by any member as a result of his or her participation
174 in the clinical trial.
175 (28) “Person” means any individual, company, association, organization, corporation or
176 other legal entity, including, but not limited to, hospital, medical or dental service corporations;
177 health maintenance organizations or similar organization providing prepaid health benefits; or
178 individuals entitled to benefits under the provisions of this article.

179 (29) “Plan”, unless the context indicates otherwise, means the medical indemnity plan, the
180 managed care plan option or the group life insurance plan offered by the agency.
181 (30) “Preexisting Condition” means an injury, or sickness, or any condition relating to that
182 injury, or sickness, for which a participant is diagnosed, receives treatment, or incurs expenses
183 prior to the effective date of coverage.
184 (31) "Primary Coverage" means individual or group hospital and surgical insurance
185 coverage or individual or group major medical insurance coverage or group prescription drug
186 coverage in which the spouse or dependent is the named insured or certificate holder. For the
187 purposes of this section, "dependent" includes an eligible employee’s unmarried child or stepchild
188 under the age of twenty-five if that child or stepchild meets the definition of a "qualifying child" or
189 a "qualifying relative" in Section 152 of the Internal Revenue Code. The director may require
190 proof regarding spouse and dependent primary coverage and shall adopt rules governing the
191 nature, discontinuance and resumption of any employee's coverage for his or her spouse and
192 dependents.
193 (32) "Private carrier" means any insurer or the legal representative of an insurer authorized
194 by the insurance commissioner to provide public employees insurance pursuant to this article and
195 which maintains an office in the state.
196 (33) "Prudent layperson" means a person who is without medical training and who draws
197 on his or her practical experience when making a decision regarding whether an emergency
198 medical condition exists for which emergency treatment should be sought;
199 (34) “Public employees insurance” means insurance which provides health and surgical
200 care coverage to plan participants as set forth in this article;
201 (35) “Public Employees Insurance Council” means the council set forth in section five of
202 this article;
203 (36) “Retired employee” means an employee of the state who retired after April 29, 1971,
204 and an employee of the Higher Education Policy Commission, the Council for Community and

205 Technical College Education, a state institution of higher education or a county board of education
206 who retires on or after April 21, 1972, and all additional eligible employees who retire on or after
207 the effective date of this article, meet the minimum eligibility requirements for their respective
208 state retirement system and whose last employer immediately prior to retirement under the state
209 retirement system is a participating employer in the state retirement system and in the Public
210 Employees Insurance Agency: *Provided,* That for the purposes of this article, the employees who
211 are not covered by a state retirement system, but who are covered by a state-approved or state-
212 contracted retirement program or a system approved by the director, shall, in the case of
213 education employees, meet the minimum eligibility requirements of the state Teachers Retirement
214 System and in all other cases, meet the minimum eligibility requirements of the Public Employees
215 Retirement System and may participate in the Public Employees Insurance Agency as retired
216 employees upon terms as the director sets by rule as authorized in this article. Employers with
217 employees who are, or who are eligible to become, retired employees under this article shall be
218 mandatory participants in the Retiree Health Benefit Trust Fund created pursuant to article
219 sixteen-d of this chapter. Nonstate employers may opt out of the West Virginia other post-
220 employment benefits plan of the Retiree Health Benefit Trust Fund and elect to not provide
221 benefits under the Public Employees Insurance Agency to retirees of the nonstate employer, but
222 may do so only upon the written certification, under oath, of an authorized officer of the employer
223 that the employer has no employees who are, or who are eligible to become, retired employees
224 and that the employer will defend and hold harmless the Public Employees Insurance Agency
225 from any claim by one of the employer's past, present or future employees for eligibility to
226 participate in the Public Employees Insurance Agency as a retired employee. As a matter of law,
227 the Public Employees Insurance Agency shall not be liable in any respect to provide plan benefits
228 to a retired employee of a nonstate employer which has opted out of the West Virginia other post-
229 employment benefits plan of the Retiree Health Benefit Trust Fund pursuant to this section.
230 (37) "Stabilize" means with respect to an emergency medical condition, to provide medical

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

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

1 (a) On or before July 1, 2018, the director may take such actions as are necessary to
2 establish a Public Employees Mutual Insurance Company as a domestic, private, nonstock,
3 corporation to:
4 (1) Establish a group hospital and surgical insurance plan or plans;
5 (2) A group prescription drug insurance plan or plans;
6 (3) A group major medical insurance plan or plans; and,
7 (4) A group life and accidental death insurance plan or plans for state employees as they
8 are defined in this article.
9 (5) Transact such other kinds of insurance for which the company is otherwise qualified
10 under the provisions of this code.
11 (6) The company shall not sell, assign or transfer substantial assets or ownership of the
12 company.
13 (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
17 with the Insurance Commissioner and apply for a license with the Insurance Commissioner to
18 transact insurance business in this state. Notwithstanding any other provision of this code, the
19 Insurance Commissioner shall act on the documents within fifteen days of the filing by the

20 company.

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

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

38 (4) Within forty months of the date of the issuance of its license to transact insurance, the
39 company shall comply with the capital and surplus requirements set forth in subsection (a),
40 section five-b, article three, chapter thirty-three of this code in effect on the effective date of this
41 enactment, unless said deadline is extended by the Insurance Commissioner.

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

46 agency, instrumentality, officer or employee of the state.

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

50 (e) The company is not subject to provisions of article nine-a, chapter six of this code; the
51 provisions of chapter twenty-nine-b of this code; the provisions of article three, chapter five-a of
52 this code; the provisions of article six, chapter twenty-nine of this code; the provisions of article
53 six-a of said chapter; or the provisions of chapter twelve of this code.

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

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

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

3 (2) From the inception of the company, until December 31, 2018, the company shall be
4 governed by a provisional board of directors consisting of the three-persons on the Public
5 Employees Finance Board and four members of the Legislature. Two members of the West
6 Virginia Senate and two members of the West Virginia House of Delegates shall serve as advisory
7 nonvoting members of the board. The Governor shall appoint the legislative members to the
8 board. No more than three of the legislative members shall be of the same political party. The
9 provisional board shall have the authority to function as necessary to establish the company and
10 cause it to become operational, including the right to contract on behalf of the company. Each
11 voting board member shall receive compensation of not more than $500 per day and actual and
12 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, 2018, and for the conduct of the

16 election, to be held no later than May 1, 2018, 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 article three, chapter twenty-nine-a 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, 2018, 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
33 company in the insurance industry, one of whom is from a company with less than fifty 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
39 company;
40 (5) One shall be a consumer of served by the products offered by the company; and
41 (6) The chief executive officer of the company.

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

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

1 (a) There is hereby created the Public Employees Insurance Council within the Insurance
2 Commission.
3 (b) On or before January 1, 2019, the Governor with the advice and consent of the Senate,
4 shall appoint five voting members to the council who meet the requirements and qualifications of
5 this subsection. Two members of the West Virginia Senate and two members of the West Virginia
6 House of Delegates shall serve as advisory nonvoting members of the board. The Governor shall
7 appoint the legislative members to the board. No more than three of the legislative members may
8 be of the same political party. The Insurance Commissioner shall serve as an advisory nonvoting
9 member of the board.
10 (1) (A) Five members shall be appointed by the Governor with the advice and consent of
11 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, 2020;

14 (ii) Two members shall be appointed for a term ending June 30, 2021; and

15 (iii) Two members shall be appointed for a term ending June 30, 2022.

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. In the event

18 a vacancy occurs, it shall be filled by appointment for the unexpired term. A member whose term

19 has expired shall continue in office until a successor has been duly appointed and qualified. No

20 member of the council may be removed from office by the Governor except for official misconduct,

21 incompetency, neglect of duty or gross immorality.

22 (C) No appointed member may be a candidate for or hold elected office. Members may

23 be reappointed for no more than two full terms.

24 (2) Each of the appointed voting members of the council shall be appointed based upon

25 his 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.

32 The Governor shall consider the following guidelines when determining whether potential

33 candidates meet the qualifications of this subsection: Expertise in insurance claims management;

34 expertise in insurance underwriting; expertise in the financial management of pensions or

35 insurance plans; expertise as a trustee of pension or trust funds of more than two hundred

36 beneficiaries or $300 million; expertise in loss prevention and rehabilitation; expertise in medicine

37 demonstrated by licensure as a medical doctor in West Virginia and experience, board

38 certification or university affiliation; or 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 it's 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 shall
50 impair the right of a quorum to exercise all the rights and perform all the duties of the council. No
51 action shall 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 is entitled to be reimbursed for actual
57 and necessary expenses incurred for each day or portion thereof engaged in the discharge of
58 official duties in a manner consistent with guidelines of the travel management office of the
59 department of 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 article twelve, chapter twenty-nine of
63 this code.

64 (c) The council shall:

65 (1) In consultation with the Insurance Commissioner, establish operating guidelines and

66 policies designed to ensure the effective administration of the Public Employees Insurance Mutual
67 Insurance Company in West Virginia.
68 (2) Review and approve, reject or modify rules that are proposed by the Insurance
69 Commissioner for operation and regulation of the Public Employees Mutual Insurance Company
70 before the rules are filed with the Secretary of State. The rules adopted by the council are not
71 subject to sections nine through sixteen, inclusive, article three, chapter twenty-nine-a of this
72 code. The council shall follow the remaining provisions of said chapter for giving notice to the
73 public of its actions and for holding hearings and receiving public comments on the rules.
74 (3) In accordance with the laws and rules of West Virginia, establish and monitor
75 performance standards and measurements to ensure the timeliness and accuracy of activities
76 performed under this article and applicable rules.
77 (4) Submit for approval by the Legislature, as an isolated and clearly discernable
78 component of the Insurance Commissioner's budget, a budget for the sufficient administrative
79 resources and funding requirements necessary for their duties under this article.
80 (5) Perform all record and information gathering functions necessary to carry out its duties
81 under this code.
82 (6) Every two years, conduct an overview of the initiatives currently being utilized in the
83 insurance industry which could be utilized in the operation and management of the company and
84 report said findings to the Joint Committee on Government and Finance. Each private carrier
85 licensed and doing business in West Virginia shall cooperate with the council in the performance
86 of its duties to evaluate insurer services. Each entity of state government, including, but not
87 limited to, state boards, agencies, commissions, departments, institutions or spending units shall
88 provide to the council, upon request, any information, statistics or data in its records requested
89 by the council in the performance of these duties.
90 (7) Perform all other duties as specifically provided in this article for the council and those
91 duties incidental thereto.

92 (d) The Public Employees Insurance Council shall:

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

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

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

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

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

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

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

118 provided to control losses and provide information on the prevention other healthcare initiatives
119 for disease awareness and prevention. Employers and private carriers shall provide to the
120 council, upon request, any information, statistics or data in its records requested by the council in
121 the performance of these duties.
122 (8) The council shall elect one member to serve as chairperson.
123 (9) Perform all other duties as specifically provided in this chapter for the industrial council
124 and those duties incidental thereto.
125 (10) Establish a method of indexing claims that will make information concerning one
126 insurer available to other insurers.

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

1 (a) Effective upon the date upon which this enactment is made effective by the Legislature,
2 there is hereby established in the State Treasury a "Public Employees Old Fund", "Public
3 Employees New Fund", "Mutualization Transition Fund" and an "Assigned Risk Fund". The
4 Director of the Public Employees Insurance Agency shall have full authority to administer the old
5 fund, the new fund and the mutualization transition fund until termination of the agency. As soon
6 as practicable upon the establishment of the mutualization transition fund, the director shall cause
7 an amount determined by the West Virginia Commissioner of Insurance and approved by the
8 Joint Committee on Government and Finance to be transferred from the Public Employees
9 Insurance fund into the Mutualization Transition Fund. If the proclamation set forth in this article
10 has not been issued, all unencumbered funds remaining in the Mutualization Transition Fund as
11 of termination of the agency shall be transferred back to the Public Employees Insurance Fund.
12 (b) If the proclamation set forth in this article is issued, then upon termination of the
13 agency, the funds contained in the Public Employees Insurance Fund shall be disbursed with an
14 amount determined by the West Virginia Commissioner of Insurance and approved by the Joint
15 Committee on Government and Finance into the Public Employee Insurance Old Fund, the exact

16 amount of which shall be set forth in the governor's proclamation provided in this article and the
17 remainder 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,
6 the administrator of the funds or the Insurance Commissioner, whichever is applicable. The
7 Public Employees Insurance Old Fund and the Assigned Risk Fund are participant plans as
8 defined in section two, article six, chapter twelve of this code and are subject to the provisions of
9 section nine-a of said article. The funds may be invested by the Investment Management Board
10 in accordance with said article.
11 (b) If the Governor issues the proclamation set forth in this article, then, effective upon
12 termination of the agency, all remaining assets and funds contained in the Public Employees Fund
13 which are payable to the new fund shall be so disbursed and paid to the company in a manner
14 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
12 be transferred from the Public Employees Insurance Fund to the old fund. Said proclamation
13 shall not be effective any earlier than June 30, 2016.

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
18 and 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 shall have sole authority to identify
22 and select the employees that are employed by the agency to be assigned and transferred to the
23 Insurance 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 shall 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, 2019, 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, 2020, 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
4 first 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, must 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
10 be payable out of the mutualization transition fund.

11 (b) The public employees' retirement system shall take such action as is necessary to
12 carry 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 forty days.

24 (d) The Division of Personnel shall cooperate fully by assisting in all activities necessary
25 to expedite all changes for the agency and agency employees, including, but not limited to, all of
26 the 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
6 group prescription drug insurance plan or plans, a group major medical insurance plan or plans
7 and a group life and accidental death insurance plan or plans for those employees who are eligible
8 and administer these plans subject to the limitations contained in this article. These plans shall
9 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
12 States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology,
13 whichever is medically appropriate, and consistent with the current guidelines from either the
14 United States Preventive Services Task Force or The American College of Obstetricians and
15 Gynecologists; and a test for the human papilloma virus (HPV) when medically appropriate and
16 consistent with current guidelines from either the United States Preventive Services Task Force
17 or The American College of Obstetricians and Gynecologists, when performed for cancer
18 screening or diagnostic services on a woman age eighteen or over;

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

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

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

29 (5) For plans which provide coverages for post-delivery care to a mother and her newly
30 born child in the home, coverage for inpatient care following childbirth as provided in subdivision

31 (4) of this subsection if inpatient care is determined to be medically necessary by the attending
32 physician. These plans may include, among other things, medicines, medical equipment,
33 prosthetic appliances and any other inpatient and outpatient services and expenses considered
34 appropriate and desirable by the agency; and
35 (6) Coverage for treatment of serious mental illness:
36 (A) The coverage does not include custodial care, residential care or schooling. For
37 purposes of this section, "serious mental illness" means an illness included in the American
38 Psychiatric Association's Diagnostic and Statistical Manual of mental disorders, as periodically
39 revised, under the diagnostic categories or subclassifications of: (i) Schizophrenia and other
40 psychotic disorders; (ii) bipolar disorders; (iii) depressive disorders; (iv) substance-related
41 disorders with the exception of caffeine-related disorders and nicotine-related disorders; (v)
42 anxiety disorders; and (vi) anorexia and bulimia. With regard to a covered individual who has not
43 yet attained the age of nineteen years, "serious mental illness" also includes attention deficit
44 hyperactivity disorder, separation anxiety disorder and conduct disorder.
45 (B) Notwithstanding any other provision in this section to the contrary, if the company
46 demonstrates that its total costs for the treatment of mental illness for any plan exceeds two
47 percent of the total costs for such plan in any experience period, then the company may apply
48 whatever additional cost-containment measures may be necessary in order to maintain costs
49 below two percent of the total costs for the plan for the next experience period. These measures
50 may include, but are not limited to, limitations on inpatient and outpatient benefits.
51 (C) The company shall not discriminate between medical-surgical benefits and mental
52 health benefits in the administration of its plan. With regard to both medical-surgical and mental
53 health benefits, it may make determinations of medical necessity and appropriateness and it may
54 use recognized health care quality and cost management tools including, but not limited to,
55 limitations on inpatient and outpatient benefits, utilization review, implementation of cost-
56 containment measures, preauthorization for certain treatments, setting coverage levels, setting

57 maximum number of visits within certain time periods, using capitated benefit arrangements,
58 using fee-for-service arrangements, using third-party administrators, using provider networks and
59 using patient cost sharing in the form of copayments, deductibles and coinsurance.
60 (7) Coverage for general anesthesia for dental procedures and associated outpatient
61 hospital or ambulatory facility charges provided by appropriately licensed health care individuals
62 in conjunction with dental care if the covered person is:
63 (A) Seven years of age or younger or is developmentally disabled and is an individual for
64 whom a successful result cannot be expected from dental care provided under local anesthesia
65 because of a physical, intellectual or other medically compromising condition of the individual and
66 for whom a superior result can be expected from dental care provided under general anesthesia;
67 (B) A child who is twelve years of age or younger with documented phobias or with
68 documented mental illness and with dental needs of such magnitude that treatment should not be
69 delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of
70 teeth or other increased oral or dental morbidity and for whom a successful result cannot be
71 expected from dental care provided under local anesthesia because of such condition and for
72 whom a superior result can be expected from dental care provided under general anesthesia.
73 (8) (A) Any plan issued shall include coverage for diagnosis, evaluation and treatment of
74 autism spectrum disorder in individuals ages eighteen months to eighteen years. To be eligible
75 for coverage and benefits under this subdivision, the individual must be diagnosed with autism
76 spectrum disorder at age eight or younger. Such plan shall provide coverage for treatments that
77 are medically necessary and ordered or prescribed by a licensed physician or licensed
78 psychologist and in accordance with a treatment plan developed from a comprehensive
79 evaluation by a certified behavior analyst for an individual diagnosed with autism spectrum
80 disorder.
81 (B) The coverage shall include, but not be limited to, applied behavior analysis which shall
82 be provided or supervised by a certified behavior analyst. The annual maximum benefit for

83 applied behavior analysis required by this subdivision shall be in an amount not to exceed $30,000
84 per individual for three consecutive years from the date treatment commences. At the conclusion
85 of the third year, coverage for applied behavior analysis required by this subdivision shall be in
86 an amount not to exceed $2,000 per month, until the individual reaches eighteen years of age, as
87 long as the treatment is medically necessary and in accordance with a treatment plan developed
88 by a certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the
89 individual. This subdivision does not limit, replace or affect any obligation to provide services to
90 an individual under the Individuals with Disabilities Education Act, 20 U. S. C. 1400 et seq., as
91 amended from time to time or other publicly funded programs. Nothing in this subdivision requires
92 reimbursement for services provided by public school personnel.
93 (C) The certified behavior analyst shall file progress reports with the agency semiannually.
94 In order for treatment to continue, the agency must receive objective evidence or a clinically
95 supportable statement of expectation that:
96 (i) The individual's condition is improving in response to treatment;
97 (ii) A maximum improvement is yet to be attained; and
98 (iii) There is an expectation that the anticipated improvement is attainable in a reasonable
99 and generally predictable period of time.
100 (D) To the extent that the application of this subdivision for autism spectrum disorder
101 causes an increase of at least one percent of actual total costs of coverage for the plan year, the
102 agency may apply additional cost containment measures.
103 (E) To the extent that the provisions of this subdivision require benefits that exceed the
104 essential health benefits specified under section 1302(b) of the Patient Protection and Affordable
105 Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified
106 essential health benefits shall not be required of insurance plans offered by the company.
107 (9) For plans that include maternity benefits, coverage for the same maternity benefits for
108 all individuals participating in or receiving coverage under plans that are issued or renewed on or

109 after January 1, 2014: *Provided,* That to the extent that the provisions of this subdivision require
110 benefits that exceed the essential health benefits specified under section 1302(b) of the Patient
111 Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that
112 exceed the specified essential health benefits shall not be required of a health benefit plan when
113 the plan is offered in this state.

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

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

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

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

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

135 (B) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
136 and
137 (C) Prostheses and physical complications of mastectomy, including lymphedemas in a
138 manner determined in consultation with the attending physician and the patient. Coverage shall
139 be provided for a minimum stay in the hospital of not less than forty-eight hours for a patient
140 following a radical or modified mastectomy and not less than twenty-four hours of inpatient care
141 following a total mastectomy or partial mastectomy with lymph node dissection for the treatment
142 of breast cancer. Nothing in this section shall be construed as requiring inpatient coverage where
143 inpatient coverage is not medically necessary or where the attending physician in consultation
144 with the patient determines that a shorter period of hospital stay is appropriate. Such coverage
145 may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate
146 and as are consistent with those established for other benefits under the plan. Written notice of
147 the availability of such coverage shall be delivered to the participant upon enrollment and annually
148 thereafter in the summary plan description or similar document. The plan may not deny to a patient
149 eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely
150 for the purpose of avoiding the requirements of this section; and penalize or otherwise reduce or
151 limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to
152 an attending provider, to induce such provider to provide care to an individual participant or
153 beneficiary in a manner inconsistent with this section.
154 (D) Nothing in this section shall be construed to prevent a health benefit plan policy or a
155 health insurer offering health insurance coverage from negotiating the level and type of
156 reimbursement with a provider for care provided in accordance with this section.
157 (12) Coverage for patient cost of clinical trials.
158 (A) The provisions of this section apply to the health plans regulated by this article.
159 (B) This section does not apply to a policy, plan or contract paid for under Title XVIII of the
160 Social Security Act.

161 (C) A policy, plan or contract subject to this section shall provide coverage for patient cost
162 to a member in a clinical trial, as a result of:
163 (i) Treatment provided for a life-threatening condition; or
164 (ii) Prevention of, early detection of or treatment studies on cancer.
165 (D) The coverage under paragraph(C) of this section is required if the treatment is being
166 provided or the studies are being conducted in a Phase II, Phase III or Phase IV clinical trial for
167 cancer and has therapeutic intent or the treatment is being provided in a Phase II, Phase III or
168 Phase IV clinical trial for any other life-threatening condition and has therapeutic intent or, the
169 treatment is being provided in a clinical trial approved by one of the national institutes of health,
170 an NIH cooperative group or an NIH center, the FDA in the form of an investigational new drug
171 application or investigational device exemption, the federal Department of Veterans Affairs or, an
172 institutional review board of an institution in the state which has a multiple project assurance
173 contract approved by the office of protection from research risks of the national institutes of health;
174 (iii) The facility and personnel providing the treatment are capable of doing so by virtue of
175 their experience, training and volume of patients treated to maintain expertise;
176 (iv) There is no clearly superior, noninvestigational treatment alternative;
177 (v) The available clinical or preclinical data provide a reasonable expectation that the
178 treatment will be more effective than the noninvestigational treatment alternative;
179 (vi) The treatment is provided in this state: *Provided,* That, if the treatment is provided
180 outside of this state, the treatment must be approved by the payor designated in subsection (a)
181 of this section;
182 (vii) Reimbursement for treatment is subject to all coinsurance, copayment and
183 deductibles and is otherwise subject to all restrictions and obligations of the health plan; and
184 (viii) Reimbursement for treatment by an out of network or noncontracting provider shall
185 be reimbursed at a rate which is no greater than that provided by an in network or contracting
186 provider. Coverage shall not be required if the out of network or noncontracting provider will not

187 accept this level of reimbursement.

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

189 section, if:

190 (i) The purpose of the clinical trial is designed to extend the patent of any existing drug, to

191 gain approval or coverage of a metabolite of an existing drug, or to gain approval or coverage

192 relating to additional clinical indications for an existing drug; or

193 (ii) The purpose of the clinical trial is designed to keep a generic version of a drug from

194 becoming available on the market; or

195 (iii) The purpose of the clinical trial is to gain approval of or coverage for a reformulated or

196 repackaged version of an existing drug.

197 (F) Any provider billing a third party payor for services or products provided to a patient in

198 a clinical trial shall provide written notice to the payor that specifically identifies the services as

199 part of a clinical trial.

200 (G) Notwithstanding any provision in this section to the contrary, coverage is not required

201 for Phase I of any clinical trial.

202 (b) The company shall, with full authorization, make available to each eligible employee,

203 at full cost to the employee, the opportunity to purchase optional group life and accidental death

204 insurance as established under the rules of the agency. In addition, each employee is entitled to

205 have his or her spouse and dependents, as defined by the rules of the agency or by the company,

206 included in the optional coverage, at full cost to the employee, for each eligible dependent.

207 (c) The company may cause to be separately rated for claims experience purposes:

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

209 (2) All teaching and professional employees of state public institutions of higher education

210 and county boards of education;

211 (3) All nonteaching employees of the Higher Education Policy Commission, West Virginia

212 Council for Community and Technical College Education and county boards of education; or

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

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

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

1 (a) The provisions of this article are not mandatory upon any employee or employer who
2 is 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 two-b, chapter twenty-one-a of this code may not be required to enroll in or subscribe to an
8 insurance plan or plans authorized by the provisions of this article, and the employees of any
9 department which has an existing insurance program for its employees to which the government
10 of the United States contributes any part or all of the premium or cost of the premium may be
11 exempted from the provisions of this article. Any employee or employer exempted under the
12 provisions of this paragraph may enroll in any insurance program authorized by the provisions of
13 this article at any time, to the same extent as any other qualified employee or employer, but
14 employee or employer may not remain enrolled in both programs. The provisions of articles
15 fourteen, fifteen and sixteen, chapter thirty-three of this code, relating to group life insurance,
16 accident and sickness insurance, and group accident and sickness insurance, are not applicable
17 to the provisions of this article whenever the provisions of articles fourteen, fifteen and sixteen,
18 chapter thirty-three of this code are in conflict with or contrary to any provision set forth in this

19 article or to any plan or plans established by the company.

20 (c) Employers, other than the State of West Virginia, its boards, agencies, commissions,
21 departments, institutions, spending units or a county board of education are exempt from
22 participating in the insurance program provided for by the provisions of this article unless
23 participation by the employer has been approved by a majority vote of the employer's governing
24 body. It is the duty of the clerk or secretary of the governing body of an employer who, by majority
25 vote, becomes a participant in the insurance program to notify the director not later than ten days
26 after the vote.

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

45 payments as are required by this section.

46 (e) Any person employed by the State of West Virginia on or before the transfer date may
47 use their accrued and unused sick leave at the time of retirement for those purposes that would
48 have been available to the employee under law in existence at the date of the transfer had the
49 employee retired on the transfer date, including use of sick leave at the time of retirement to
50 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, 2022, and four percent of claims paid each month
7 for the administration of the old fund thereafter through the June 30, 2024. 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 article three, chapter five-a of this code.

13 (b) The Insurance Commissioner may contract or employ counsel to perform legal
14 services 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, 2018, 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
18 to be performed on the old fund.

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

(a) For the fiscal year beginning July 1, 2019, the company shall charge the actuarially determined base rates for the fiscal year. The base rates shall be calculated by the company and submitted for approval by the Insurance Commissioner.

(b) For the fiscal year beginning July 1, 2019, the company shall charge the actuarially determined base rates for said fiscal year. The base rates shall be calculated by the company and submitted for approval by the Insurance Commissioner.

(c) Effective for the fiscal year beginning July 1, 2020, all private carriers' rates shall be governed by the following:

(1) For the period beginning on July 1, 2020, and ending on June 30, 2021, no more than five percent variance from the base rates established by the Insurance Commissioner.

(2) For the period beginning on July 1, 2021, and ending on June 30, 2022, no more than ten percent variance from the base rates established by the Insurance Commissioner.

(d) The Insurance Commissioner retains authority to disapprove rates in effect if it is determined that the rates are not in compliance with the following:

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

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

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

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

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

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

(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
28 high in relation to the risk of the class of business, or if expenses are unreasonably high in relation
29 to the services rendered.
30 (3) Rates are inadequate if they are clearly insufficient, together with the income from
31 investments attributable to them, to sustain projected losses and expenses in the class.
32 (4) One rate is unfairly discriminatory in relation to another in the same class if it clearly
33 fails to reflect equitably the differences in expected losses and expenses. Rates are not unfairly
34 discriminatory because different premiums result for policyholders with similar exposure to loss
35 but different expense factors, or similar expense factors but different exposure to loss, so long as
36 the rates reflect the differences with reasonable accuracy. Rates are not unfairly discriminatory
37 if they are averaged broadly among persons insured under a group, franchise or blanket policy.

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

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

§5-16A-17. Rules.

1 Except as otherwise provided in this chapter, all rules applicable to the former Public
2 Employees Insurance Agency are hereby adopted and made effective as to the operation of the
3 public employees insurance market to the extent that they are not in conflict with the current law.
4 Authority to enforce the existing rules and the regulatory functions of the agency as set forth in
5 chapter five of the code shall transfer from the agency to the Insurance Commissioner effective
6 upon termination of the agency. The Insurance Commissioner shall review and seek approval,
7 modification or replacement, through the public employees insurance council, of all existing rules
8 no later than July 1, 2019.

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

1 With the establishment of the company, all agency assets, including, but not limited to, all
2 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 shall 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 shall 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.