

# **WEST VIRGINIA LEGISLATURE**

## **2023 REGULAR SESSION**

**Introduced**

### **House Bill 2534**

By Delegates Summer and Forsht

[Introduced January 13, 2023; Referred to the  
Committee on Banking and Insurance then Finance]

1 A BILL to repeal §5-16-5a and §5-16-5b of the Code of West Virginia, 1931, as amended; to  
 2 amend and reenact §5-16-2, §5-16-3, §5-16-4, §5-16-5, §5-16-7, §5-16-7b, §5-16-7c, §5-  
 3 16-7g, §5-16-8, §5-16-9, §5-16-10, §5-16-11, §5-16-13, §5-16-14, §5-16-15, §5-16-16, §5-  
 4 16-18, §5-16-23, §5-16-25, §5-16-26, §5-16-28; and to amend said code by adding thereto  
 5 one new section, designated §5-16-30; relating to public employees insurance.

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

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

**§5-16-2. Definitions.**

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

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

4 "Dependent" includes an eligible employee's child under the age of 25 as defined in the  
 5 Patient Protection and Affordable Care Act.

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

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

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

16 (2) "Director" means the Director of the Public Employees Insurance Agency created by  
 17 this article.

18 "Distant site" means the telehealth site where the health care practitioner is seeing the

19 patient at a distance or consulting with a patient's health care practitioner.

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

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

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

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

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

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

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

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

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

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

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

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

94 "Objective evidence" means standardized patient assessment instruments, outcome  
95 measurements tools, or measurable assessments of functional outcome. Use of objective  
96 measures at the beginning of treatment, during, and after treatment is recommended to quantify

97 progress and support justifications for continued treatment. The tools are not required but their use  
98 will enhance the justification for continued treatment.

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

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

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

110 (1) Rapid-acting;

111 (2) Short-acting;

112 (3) Intermediate-acting;

113 (4) Long-acting;

114 (5) Pre-mixed insulin products;

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

116 (7) Concentrated human regular insulin.

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

120 "Remote patient monitoring services" means the delivery of home health services using  
121 telecommunications technology to enhance the delivery of home health care, including monitoring  
122 of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and

123 other condition-specific data; medication adherence monitoring; and interactive video  
124 conferencing with or without digital image upload.

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

149 Insurance Agency shall not be liable in any respect to provide plan benefits to a retired employee  
150 of a nonstate employer which has opted out of the West Virginia other post-employment benefits  
151 plan of the Retiree Health Benefit Trust Fund pursuant to this section.

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

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

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

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

12 (b) Except for the director, his or her personal secretary, the deputy director and the chief  
13 financial officer, all positions in the agency shall be included in the classified service of the civil



14 service system pursuant to ~~article six, chapter twenty-nine~~ §29-6-1 et seq. of this code.

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

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

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

- 37 (1) Increasing generic fill rates;
- 38 (2) Managing specialty pharmacy costs;
- 39 (3) Implementing and evaluating medical home models and health care delivery;

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

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

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

47 (7) Evaluating the expenditures to reduce excessive use of emergency room visits,  
48 imaging services and other drivers of the agency's medical rate of inflation;

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

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

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

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

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

65 ~~(f) The director shall issue an annual progress report to the Joint Committee on~~

66 ~~Government and Finance on the implementation of any reforms initiated pursuant to this section~~  
67 ~~and other initiatives developed by the agency~~

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

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

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

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

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

22 a public body for the duration of his or her appointment to remain eligible to serve on the board.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (a) The purpose of the finance board ~~created by this article~~ is to bring fiscal stability to the

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

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

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

24 (1) ~~Maximum levels of reimbursement which the Public Employees Insurance Agency~~  
25 ~~makes to categories of health care providers~~ The minimum level of reimbursement is 110% of the  
26 amount Medicare;

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

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

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

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

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

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

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

54 met.

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

58 ~~(4) Any financial plan shall be designed to allow thirty days or less of accounts payable to~~  
59 ~~be carried over into the next fiscal year~~ For each fiscal year, the Governor shall provide his or her  
60 estimate of total revenues to the finance board no later than October 15, of the preceding fiscal  
61 year. ~~Provided, That, for The prospective financial plans required by this section~~ The Governor  
62 shall estimate the revenues available for each fiscal year of the plans based on the estimated  
63 percentage of growth in general fund revenues. The finance board shall submit its final, approved  
64 financial plan ~~after obtaining the necessary actuary's opinion and conducting one or more public~~  
65 ~~hearings in each congressional district~~ to the Governor and to the Legislature no later than  
66 January 1, preceding the fiscal year. The financial plan for a fiscal year becomes effective and  
67 shall be implemented by the director on July 1, of the fiscal year. In addition to each final, approved  
68 financial plan required under this section, the finance board shall also simultaneously submit  
69 financial statements based on generally accepted accounting practices (GAAP) and the final,  
70 approved plan restated on an accrual basis of accounting, which shall include allowances for  
71 incurred but not reported claims. ~~Provided, however, That~~ The financial statements and the  
72 accrual-based financial plan restatement shall not affect the approved financial plan.

73 (e) The provisions of §29A-1-1 *et seq.* shall not apply to the preparation, approval and  
74 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 in  
82 accordance §5-16-5(d)(4) and shall include an average of the projected cost-sharing percentages  
83 of premiums and an average of the projected deductibles and copays for the various programs.  
84 ~~Beginning in the plan year which commences on July 1, 2002, and in each plan year thereafter,~~  
85 ~~until and including the plan year which commences on July 1, 2006, the prospective plans shall~~  
86 ~~include incremental adjustments toward the ultimate level required in this subsection, in the~~  
87 ~~aggregate cost-sharing percentages of premium between employers and employees, including~~  
88 ~~the amounts of any subsidization of retired employee benefits. Effective in the plan year~~  
89 ~~commencing on July 1, 2006, and in Each plan year, thereafter~~ the aggregate premium cost-  
90 sharing percentages between employers and employees, including the amounts of any  
91 subsidization of retired employee benefits, shall be at a level of 80% for the employer and 20% for  
92 employees, except for the employers provided in §5-16-18(d) whose premium cost-sharing  
93 percentages shall be governed by that subsection. After the submission of the initial prospective  
94 plan, the board may not increase costs to the participating employers or change the average of the  
95 premiums, deductibles and copays for employees, except in the event of a true emergency. as  
96 ~~provided in this section: *Provided*, That~~ If the board invokes the emergency provisions, the cost  
97 shall be borne between the employers and employees in proportion to the cost-sharing ratio for  
98 that plan year. ~~*Provided, however*, That~~ For purposes of this section, "emergency" means that the  
99 most recent projections demonstrate that plan expenses will exceed plan revenues by more than  
100 one percent in any plan year. ~~*Provided further*, That~~ The aggregate premium cost-sharing  
101 percentages between employers and employees, including the amounts of any subsidization of  
102 retired employee benefits, may be offset, in part, by a legislative appropriation for that purpose.

103 (h) The finance board shall meet on at least a quarterly basis to review implementation of  
104 its current financial plan in light of the actual experience of the Public Employees Insurance  
105 Agency. The board shall review actual costs incurred, any revised cost estimates provided by the

106 actuary, expenditures and any other factors affecting the fiscal stability of the plan and may make  
 107 any additional modifications to the plan necessary to ensure that the total financial requirements of  
 108 the agency for the current fiscal year are met. The finance board may not increase the types and  
 109 levels of cost to employees during its quarterly review except in the event of a true emergency.

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

**§5-16-5a. Retiree premium subsidy from Retiree Health Benefit Trust for hires prior to July  
 1, 2010.**

[Repealed.]

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

[Repealed.]

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

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

6 (1) Coverages and benefits for x-ray and laboratory services in connection with  
 7 mammograms when medically appropriate and consistent with current guidelines from the United  
 8 States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology,  
 9 whichever is medically appropriate and consistent with the current guidelines from either the

10 United States Preventive Services Task Force or the American College of Obstetricians and  
11 Gynecologists; and a test for the human papilloma virus when medically appropriate and  
12 consistent with current guidelines from either the United States Preventive Services Task Force or  
13 the American College of Obstetricians and Gynecologists, when performed for cancer screening  
14 or diagnostic services on a woman age 18 or over;

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

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

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

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

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

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

- 36 (i) Schizophrenia and other psychotic disorders;  
37 (ii) bipolar disorders;  
38 (iii) depressive disorders;  
39 (iv) substance-related disorders with the exception of caffeine-related disorders and  
40 nicotine-related disorders;  
41 (v) anxiety disorders; and  
42 (vi) anorexia and bulimia.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

114 ~~measurement, and functional analysis of the relationship between environment and behavior.~~

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

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

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

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

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

138 (10) (A) ~~A policy, plan, or contract that is issued or renewed on or after January 1, 2019,~~  
139 ~~and that is subject to this section, shall provide Coverage, through the age of 20, for amino acid-~~

140 based formula for the treatment of severe protein-allergic conditions or impaired absorption of  
141 nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the  
142 gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder  
143 by a physician licensed to practice in this state pursuant to either §30-3-1 *et seq.* or §30-14-1 *et*  
144 *seq.* of this code:

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

147 (ii) Severe food protein-induced enterocolitis syndrome;

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

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

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

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

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

160 (11) The cost for coverage of children's immunization services from birth through age 16  
161 years to provide immunization against the following illnesses: Diphtheria, polio, mumps, measles,  
162 rubella, tetanus, hepatitis-b, hemophilia influenzae-b, and whooping cough. Additional  
163 immunizations may be required by the Commissioner of the Bureau for Public Health for public  
164 health purposes. Any contract entered into to cover these services shall require that all costs  
165 associated with immunization, including the cost of the vaccine, if incurred by the healthcare



166 provider, and all costs of vaccine administration be exempt from any deductible, per visit charge  
167 and/or copayment provisions which may be in force in these policies or contracts. This section  
168 does not require that other healthcare services provided at the time of immunization be exempt  
169 from any deductible and/or copayment provisions.

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

172 (b) The agency shall ~~with full authorization~~ make available to each eligible employee, at full  
173 cost to the employee, the opportunity to purchase optional group life and accidental death  
174 insurance as established under the rules of the agency. In addition, each employee is entitled to  
175 have his or her spouse and dependents, as defined by the rules of the agency, included in the  
176 optional coverage, at full cost to the employee, for each eligible dependent. The group life and  
177 accidental death insurance herein provided shall be in the amount of \$10,000 for every employee.  
178 The amount of the group life and accidental death insurance to which an employee would  
179 otherwise be entitled shall be reduced to \$5,000 upon such employee attaining age 65.

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

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

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

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

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

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

192 agency.

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

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

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

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

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

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

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

218 mental health, and substance use disorder benefit.

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

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

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

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

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

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

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

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

243 (A) Identify factors used to determine whether a nonquantitative treatment limitation will

244 apply to a benefit, including factors that were considered but rejected;

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

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

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

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

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

268 (j) The Public Employees Insurance Agency shall update its annual plan document to  
269 reflect its comprehensive parity compliance. An annual report shall also be filed with the Joint

270 Committee on Government and Finance and the Public Employees Insurance Agency Finance  
271 Board.

272 ~~(k) This section is effective for policies, contracts, plans or agreements, beginning on or~~  
273 ~~after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject~~  
274 ~~to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on~~  
275 ~~or after the effective date of this section~~ The Public Employees Insurance Agency may increase  
276 the member's cost share for services provided in a contiguous bordering county.

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

1 (a) The following terms are defined:

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

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

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

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

16 (5) ~~"Remote patient monitoring services" means the delivery of home health services using~~  
17 ~~telecommunications technology to enhance the delivery of home health care, including monitoring~~  
18 ~~of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and~~

19 ~~other condition-specific data; medication adherence monitoring; and interactive video~~  
20 ~~conferencing with or without digital image upload.~~

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

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

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

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

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

43 ~~(e) (d)~~ The plan may not impose any annual or lifetime dollar maximum on coverage for  
44 telehealth services other than an annual or lifetime dollar maximum that applies in the aggregate

45 to all items and services covered under the policy, or impose upon any person receiving benefits  
46 pursuant to the provisions of or the requirements of this section any copayment, coinsurance, or  
47 deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation  
48 or maximum for benefits or services, that is not equally imposed upon all terms and services  
49 covered under the policy, contract, or plan.

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

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

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

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

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

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

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

17 are consistent with those established for other benefits under the plan. Written notice of the  
18 availability of such coverage shall be delivered to the participant upon enrollment and annually  
19 thereafter in the summary plan description or similar document.

20 (b) The plan may not:

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

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

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

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

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

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

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

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

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

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

9 (4) ~~Long-acting;~~

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

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



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

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

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

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

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

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

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

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

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

1           (a) The insurance plans provided for in this article shall be designed by the Public  
2 Employees Insurance Agency:

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

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

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

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

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

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

20           (7) To include provisions for the coordination of benefits payable by the terms of the plans  
21 with the benefits to which the employee, or his or her spouse or his or her dependents may be

22 entitled by the provisions of any other group hospital, surgical, medical, major medical, or  
23 prescription drug insurance or any combination thereof;

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

28 (9) To provide wellness and exercise programs. Exercise programs including remote  
29 device assisted programs does not violate scope of practice laws. ~~and activities which will include,~~  
30 ~~but not be limited to, benefit plan incentives to discourage tobacco, alcohol and chemical abuse~~  
31 ~~and an educational program to encourage proper diet and exercise. In establishing "wellness"~~  
32 ~~programs, the division of vocational rehabilitation shall cooperate with the Public Employees~~  
33 ~~Insurance Agency in establishing statewide wellness programs. The director of the Public~~  
34 ~~Employees Insurance Agency shall contract with county boards of education for the use of~~  
35 ~~facilities, equipment or any service related to that purpose. Boards of education may charge only~~  
36 ~~the cost of janitorial service and increased utilities for the use of the gymnasium and related~~  
37 ~~equipment. The cost of the exercise program shall be paid by county boards of education, the~~  
38 ~~Public Employees Insurance Agency, or participating employees, their spouses or dependents. All~~  
39 ~~exercise programs shall be made available to all employees, their spouses or dependents and~~  
40 ~~shall not be limited to employees of county boards of education~~

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

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

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

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

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

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

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

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

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

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

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

**§5-16-9. Authorization to execute contracts. for group hospital and surgical insurance,**

~~group major medical insurance, group prescription drug insurance, group life and accidental death insurance, and other accidental death insurance; mandated benefits; limitations; awarding of contracts; reinsurance; certificates for covered employees; discontinuance of contracts~~

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

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

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

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

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

23 ~~18 and over;~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

70 ~~(e) (b) The provisions of §5A-3-1 *et seq.* of this code, relating to the Division of Purchasing~~  
71 ~~of the Department of Finance and Administration, shall not apply to any contracts for any~~  
72 ~~insurance coverage or professional services authorized to be executed under the provisions of~~  
73 ~~this article. Before entering into any contract for any insurance coverage, as authorized in this~~  
74 ~~article, the director shall invite competent bids from all qualified and licensed insurance companies~~



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

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

100 (g) ~~(d)~~ Each employee who is covered under any contract or contracts shall receive a

101 statement of benefits to which the employee, his or her spouse and his or her dependents are  
102 entitled under the contract, setting forth the information as to whom the benefits are payable, to  
103 whom claims shall be submitted and a summary of the provisions of the contract or contracts as  
104 they affect the employee, his or her spouse and his or her dependents.

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

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

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

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

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

126 (3) The overall total number of claims in which the pharmacy benefits manager reimbursed

127 a pharmacy provider for less than the amount charged to the agency for all claims processed by  
128 the pharmacy benefit manager during the quarter; and

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

131 (A) The cost of drug reimbursement;

132 (B) Dispensing fees;

133 (C) Copayments; and

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

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

153 providers on a quarterly basis.

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

**§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.**

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

162 In the event the Public Employees Insurance Agency provides the above benefits for  
163 retired employees, their spouses and dependents, the Public Employees Insurance Agency shall  
164 adopt rules and regulations prescribing the conditions under which retired employees may elect to  
165 participate in or withdraw from the plan or plans. Any ~~contract or contracts herein~~ plan provided for  
166 shall be secondary to any ~~hospital, surgical, major medical, prescription drug or other health~~  
167 ~~insurance plan~~ administered by the United States Department of Health and Human Services to  
168 which the retired employee, spouse or dependent may be eligible under any law or regulation of  
169 the United States. If an employee, eligible to participate in the Public Employees Insurance  
170 Agency plans, is also eligible to participate in the state Medicaid program, and chooses to do so,  
171 then the Public Employees Insurance Agency may transfer to the Medicaid program funds to pay  
172 the required state share of such employee's participation in Medicaid except that the amount  
173 transferred may not exceed the amount that would be allocated by the agency to subsidize the  
174 cost of coverage for the retired employee if he or she were enrolled in the public employee  
175 insurance agency's plans.

**§5-16-11. To whom benefits paid.**

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

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

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

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

9 (2) The spouse and dependent coverage is limited to excess or secondary coverage for  
 10 each spouse and dependent who has primary coverage from any other source. If an employee's  
 11 spouse has health insurance available through an employer not defined by §5-16-2 of this code,  
 12 then the employer may not cover any portion of premiums for the employee's spouse coverage,  
 13 but the employee may add his or her spouse to his or her coverage by paying the full spousal

14 premium at the actuarially determined amount to represent the fair market value of a comparable  
15 policy offered by a private health insurance carrier. However, for spousal premium coverage by the  
16 employer, this section does not apply to voluntary employers pursuant to section §5-16-22 of this  
17 code.

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

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

39 (d) ~~Conversion of accrued annual and sick leave for extended insurance coverage upon~~

40 ~~retirement for employees who elected to participate in the plan before July, 1988.~~ Except as  
41 otherwise provided in subsection (g) of this section, when an employee participating in the plan,  
42 who elected to participate in the plan before July 1, 1988, is compelled or required by law to retire  
43 before reaching the age of ~~sixty-five~~ 65, or when a participating employee voluntarily retires as  
44 provided by law, that employee's accrued annual leave and sick leave, if any, shall be credited  
45 toward an extension of the insurance coverage provided by this article, according to the following  
46 formulae: The insurance coverage for a retired employee shall continue one additional month for  
47 every two days of annual leave or sick leave, or both, which the employee had accrued as of the  
48 effective date of his or her retirement. For a retired employee, his or her spouse and dependents,  
49 the insurance coverage shall continue one additional month for every three days of annual leave  
50 or sick leave, or both, which the employee had accrued as of the effective date of his or her  
51 retirement.

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

66 employee who has been a participant under spouse or dependent coverage and who reenters the  
67 plan within twelve months after termination of his or her prior coverage shall be considered to have  
68 elected to participate in the plan as of the date of commencement of the prior coverage. For  
69 purposes of this subsection, an employee shall not be considered a new employee after returning  
70 from extended authorized leave on or after July 1, 1988.

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

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

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

84 ~~retirement for certain higher education employees.~~— Except as otherwise provided in subsection

85 (l) of this section, when an employee, who is a higher education full-time faculty member employed  
86 on an annual contract basis other than for ~~twelve~~ 12 months, is compelled or required by law to  
87 retire before reaching the age of ~~sixty-five~~ 65, or when such a participating employee voluntarily  
88 retires as provided by law, that employee's insurance coverage, as provided by this article, shall  
89 be extended according to the following formulae: The insurance coverage for a retired higher  
90 education full-time faculty member, formerly employed on an annual contract basis other than for  
91 ~~twelve~~ 12 months, shall continue beyond the effective date of his or her retirement one additional



92 year for each three and one-third years of teaching service, as determined by uniform guidelines  
93 established by the University of West Virginia Board of Trustees and the board of directors of the  
94 state college system, for individual coverage, or one additional year for each five years of teaching  
95 service for family coverage.

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

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

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

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

118 ~~(l) *Participation of certain former employees.*— An employee, eligible for coverage under~~  
 119 ~~the provisions of this article who has twenty years of service with any agency or entity participating~~  
 120 ~~in the public employees insurance program or who has been covered by the public employees~~  
 121 ~~insurance program for twenty years may, upon leaving employment with a participating agency or~~  
 122 ~~entity, continue to be covered by the program if the employee pays one hundred five percent of the~~  
 123 ~~cost of retiree coverage: *Provided*, That the employee shall elect to continue coverage under this~~  
 124 ~~subsection within two years of the date the employment with a participating agency or entity is~~  
 125 ~~terminated.~~

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

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

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

1 The director shall develop, implement and have in place by December 31, 1990, deductible  
 2 and employee premium programs which qualify for favorable federal income tax treatment under

3 section 125 of the Internal Revenue Code.

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

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

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

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

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

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

1 The director shall ~~on or before April 1, 1988, or as soon as practicable~~ establish a preferred

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

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

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

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

11 (b) If the general revenue appropriation for any employer, excluding county boards of  
12 education, is insufficient to cover the cost of insurance coverage for the employer's participating  
13 employees, retired employees and surviving dependents, the employer shall pay the remainder of  
14 the cost from its "personal services" or "unclassified" line items. The amount of the payments for  
15 county boards of education shall be determined by the method set forth in §18-9A-24 of this code:  
16 *Provided*, That local excess levy funds shall be used only for the purposes for which they were

17 raised: *Provided, however,* That after approval of its annual financial plan, but in no event later  
18 than December 31, of each year, the finance board shall notify the Legislature and county boards  
19 of education of the maximum amount of employer premiums that the county boards of education  
20 shall pay for covered employees during the following fiscal year.

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

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

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

40 (f) All moneys received by the Public Employees Insurance Agency shall be deposited in a  
41 special fund or funds as are necessary in the state Treasury and the Treasurer of the state is  
42 custodian of the fund or funds and shall administer the fund or funds in accordance with the

43 provisions of this article or as the director may from time to time direct. The Treasurer shall pay all  
 44 warrants issued by the State Auditor against the fund or funds as the director may direct in  
 45 accordance with the provisions of this article. All funds received by the agency, ~~including, but not~~  
 46 ~~limited to, basic insurance premiums, administrative expenses and optional life insurance~~  
 47 ~~premiums~~ shall be deposited, as determined by the director, in any of the investment pools with the  
 48 West Virginia Investment Management Board, ~~including, but not limited to, the equity and fixed~~  
 49 ~~income pools~~ with the interest income or other earnings a proper credit to all such funds for the  
 50 benefit of the Public Employees Insurance Agency.

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

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

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



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

**PEIA/Medicaid**

**Funding.**

1        ~~The provision requiring coverage for 12-month refill for contraceptive drugs codified at~~  
2        ~~§33-58-1 of this code is made applicable to the provisions of this article~~

3        Employer and employee PEIA funds may not be used to fund Medicaid.

**§5-16-30. PEIA Solvency.**

1        PEIA shall reduce the number of salary tiers over the next five years. Once the salary tiers  
2        are set by the finance board, the salary tiers may not be adjusted for that year. PEIA may not  
3        change benefits for three years. Over the next 5 years, PEIA shall incrementally increase the  
4        employee contribution and employer share to return to the 80/20. After the fifth year, PEIA shall  
5        adjust the premium rate to the Medicare rate to maintain the 80/20.

NOTE: The purpose of this bill is to protect solvency of the Public Employees Insurance Agency.

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