

ARTICLE 16B. WEST VIRGINIA CHILDREN'S HEALTH INSURANCE PROGRAM.

§5-16B-1. Expansion of health care coverage to children; creation of program; legislative directives.

(a) It is the intent of the Legislature to expand access to health services for eligible children and to pay for this coverage by using private, state and federal funds to purchase those services or purchase insurance coverage for those services. To achieve this intention, the West Virginia children's health insurance program is hereby created. The program shall be administered by the children's health insurance agency within the department of administration in accordance with the provisions of this article and the applicable provisions of Title XXI of the Social Security Act of 1997. Participation in the program may be made available to families of eligible children, subject to eligibility criteria and processes to be established, which shall not create an entitlement to coverage in any person. Nothing in this article may be construed to require any appropriation of state general revenue funds for the payment of any benefit provided for in this article. In the event that this article conflicts with the requirements of federal law, federal law governs.

(b) In developing a children's health insurance program that operates with the highest degree of simplicity and governmental efficiency, the board shall avoid duplicating functions available in existing agencies and may enter into interagency agreements for the performance of specific tasks or duties at a specific or maximum contract price.

(c) In developing benefit plans, the board may consider any cost savings, administrative efficiency or other benefit to be gained by considering existing contracts for services with state health plans and negotiating modifications of those contracts to meet the needs of the program.

(d) Upon the transfer of the functions of the children's health insurance program from the department of health and human resources to the children's health insurance agency within the department of administration, the secretary of the department of health and human resources and the secretary of the department of administration, acting jointly, are empowered to authorize and shall authorize such transfers of program funds including, but not limited to, the West Virginia children's health fund created in section seven of this article and associated investment accounts; and transfers of children's health insurance program personnel and equipment, as are necessary, to facilitate an orderly transfer of the functions of the children's health insurance program. Authority to make transfers pursuant to this subsection expires on the thirty-first day of December, two thousand.

(e) In order to enroll as many eligible children as possible in the program created by this article and to expedite the effective date of their health insurance coverage, the board shall develop and implement a plan whereby applications for enrollment may be taken at any primary care center or other health care provider, as determined by the director, and transmitted electronically to the program's offices for eligibility screening and other necessary processing. The board may use any funds available to it in the development and implementation of the plan, including grant funds or other private or public moneys.

§5-16B-2. Definitions.

As used in this article, unless the context clearly requires a different meaning:

- (a) "Agency" means the children's health insurance agency within the department of administration;
- (b) "Board" means the children's health insurance program board;
- (c) "Director" means the director of the children's health insurance agency;
- (d) "Essential community health service provider" means a health care provider that:
 - (1) Has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations which constitute a significant portion of its patient population or, in the case of a sole community provider, serves medically indigent patients within its medical capability; and
 - (2) Either waives service fees or charges fees based on a sliding scale and does not restrict access or services because of a client's financial limitations. Essential community health service provider includes, but is not limited to, community mental health centers, school health clinics, primary care centers, pediatric health clinics or rural health clinics.
- (e) "Program" means the West Virginia children's health insurance program.

§5-16B-3. Reporting requirements.

- (a) Annually on the first day of January, the director shall report to the governor and the Legislature regarding the number of children enrolled in the program or programs; the average annual cost per child per program; the estimated number of remaining uninsured children; and the outreach activities for the previous year. The report shall include any information that can be obtained regarding the prior insurance and health status of the children enrolled in programs created pursuant to this article. The report shall include information regarding the cost, quality and effectiveness of the health care delivered to enrollees of this program; satisfaction surveys; and health status improvement indicators. The agency, in conjunction with other state health and insurance agencies, shall develop indicators designed to measure the quality and effectiveness of children's health programs, which information shall be included in the annual report.
- (b) On a quarterly basis, the director shall provide reports to the legislative oversight commission on health and human resources accountability on the number of children served, including the number of newly enrolled children for the reporting period and current projections for future enrollees; outreach efforts and programs; statistical profiles of the families served and health status indicators of covered children; the average annual cost of coverage per child; the total cost of children served by provider type, service type and contract type; outcome measures for children served; reductions in uncompensated care; performance with respect to the financial plan; and any other information as the legislative oversight commission on health and human resources accountability may require.

§5-16B-4. Children's health policy board created; qualifications and removal of members; powers; duties; meetings; and compensation.

(a) There is hereby created the West Virginia children's health insurance board, which shall consist of the director of the public employees insurance agency, the secretary of the department of health and human resources, or his or her designee, and six citizen members appointed by the governor, one of whom shall represent children's interests and one of whom shall be a certified public accountant, to assume the duties of the office immediately upon appointment, pending the advice and consent of the Senate. A member of the Senate, as appointed by the Senate president and a member of the House of Delegates, as appointed by the speaker of the House of Delegates, shall serve as nonvoting members. Of the five citizen members first appointed, one shall serve one year, two shall serve two years and two shall serve three years. All subsequent appointments shall be for terms of three years, except that an appointment to fill a vacancy shall be for the unexpired term only: *Provided*, That the citizen member to be appointed upon the reenactment of this section during the regular session of the Legislature, two thousand, shall serve a term which corresponds to the term of the member initially appointed to serve one year. Three of the citizen members shall have at least a bachelor's degree and experience in the administration or design of public or private employee or group benefit programs and the children's representative shall have experience that demonstrates knowledge in the health, educational and social needs of children. No more than three citizen members may be members of the same political party and no board member shall represent or have a pecuniary interest in an entity reasonably expected to compete for contracts under this article. Members of the board shall assume the duties of the office immediately upon appointment. The director of the agency shall serve as the chairperson of the board. No member may be removed from office by the governor except for official misconduct, incompetence, neglect of duty, neglect of fiduciary duty or other specific responsibility imposed by this article or gross immorality. Vacancies in the board shall be filled in the same manner as the original appointment.

(b) The purpose of the board is to develop plans for health services or health insurance that are specific to the needs of children and to bring fiscal stability to this program through development of an annual financial plan designed in accordance with the provisions of this article.

(c) Notwithstanding any other provisions of this code to the contrary, any insurance benefits offered as a part of the programs designed by the board are exempt from the minimum benefits and coverage requirements of articles fifteen and sixteen, chapter thirty-three of this code.

(d) The board may consider adopting the maximum period of continuous eligibility permitted by applicable federal law, regardless of changes in a family's economic status, so long as other group insurance does not become available to a covered child.

(e) The board shall meet at the time and place as specified by the call of the chairperson or upon the written request to the chairperson by at least two members. Notice of each meeting shall be given in writing to each member by the chairperson at least three days in advance of the meeting. Four voting members shall constitute a quorum.

(f) For each day or portion of a day spent in the discharge of duties pursuant to this article, the

board shall pay each of its citizen members the same compensation and expense reimbursement as is paid to members of the Legislature for their interim duties.

§5-16B-4a. Continuation of children's health insurance board.

The children's health insurance board shall continue to exist, pursuant to the provisions of article ten, chapter four of this code, until the first day of July, two thousand seven, unless sooner terminated, continued or reestablished pursuant to the provisions of that article.

§5-16B-5. Director of the children's health insurance program; qualifications; powers and duties.

(a) An agency director shall be appointed by the governor, with the advice and consent of the Senate, and shall be responsible for the implementation, administration and management of the children's health insurance program created under this article. The director shall have at least a bachelor's degree and a minimum of three years' experience in health insurance administration.

(b) The director shall employ any administrative, technical and clerical employees that are required for the proper administration of the program and for the work of the board. He or she shall present recommendations and alternatives for the design of the annual plans and other actions undertaken by the board in furtherance of this article.

(c) The director is responsible for the administration and management of the program and has the power and authority to make all rules necessary to effectuate the provisions of this article. Nothing in this article may be construed as limiting the director's otherwise lawful authority to manage the program on a day-to-day basis.

(d) The director has exclusive authority to execute any contracts that are necessary to effectuate the provisions of this article: *Provided*, That the board shall approve all contracts for the provision of services or insurance coverage under the program. The provisions of article three, chapter five-a of this code, relating to the division of purchasing of the department of finance and administration, shall not apply to any contracts for any health insurance coverage, health services, or professional services authorized to be executed under the provisions of this article: *Provided, however*, That before entering into any contract the director shall invite competitive bids from all qualified entities and shall deal directly with those entities in presenting specifications and receiving quotations for bid purposes. The director shall award those contracts on a competitive basis taking into account the experience of the offering agency, corporation, insurance company or service organization. Before any proposal to provide benefits or coverage under the plan is selected, the offering agency, corporation, insurance company or service organization shall provide assurances of utilization of essential community health service providers to the greatest extent practicable. In evaluating these factors, the director may employ the services of independent, professional consultants. The director shall then award the contracts on a competitive basis.

(e) The director shall issue requests for proposals on a regional or statewide basis from essential community health service providers for defined portions of services under the children's health

insurance plan and shall, to the greatest extent practicable, either contract directly with, or require participating providers to contract

with, essential community health service providers to provide the services under the plan.

(f) Subject to the advice and consent of the board, the director may require reinsurance of primary contracts, as contemplated in the provisions of sections fifteen and fifteen-a, article four, chapter thirty-three of this code.

§5-16B-6. Financial plans requirements.

(a) *Benefit plan design.* -- All financial plans required by this section shall establish: (1) The design of a benefit plan or plans; (2) the maximum levels of reimbursement to categories of health care providers; (3) any cost containment measures for implementation during the applicable fiscal year; and (4) the types and levels of cost to families of covered children. To the extent compatible with simplicity of administration, fiscal stability and other goals of the program established in this article, the financial plans may provide for different levels of costs based on ability to pay.

(b) *Actuary requirements.* -- Any financial plan, or modifications, approved or proposed by the board shall be submitted to and reviewed by an actuary before final approval. The financial plan shall be submitted to the governor and the Legislature with the actuary's written professional opinion that all estimated program and administrative costs of the agency under the plan, including incurred but unreported claims, will not exceed ninety percent of the funding available to the program for the fiscal year for which the plan is proposed and that the financial plan allows for no more than thirty days of accounts payable to be carried over into the next fiscal year. This actuarial requirement is in addition to any requirement imposed by Title XXI of the Social Security Act of 1997.

(c) *Annual plans.* -- The board shall review implementation of its current financial plan in light of actual experience and shall prepare an annual financial plan for each fiscal year during which the board remains in existence. For each fiscal year, the governor shall provide an estimate of requested appropriations and total funding available to the board no later than the fifteenth day of October preceding the fiscal year. The board shall afford interested and affected persons an opportunity to offer comment on the plan at a public meeting of the board and, in developing any proposed plan under this article, shall solicit comments in writing from interested and affected persons. The board shall submit its final, approved financial plan, subject to the actuarial requirements of this article, to the governor and to the Legislature no later than the first day of January preceding the fiscal year. The financial plan for a fiscal year becomes effective and shall be implemented by the director on the first day of July of that fiscal year. Annual plans developed pursuant to this subsection are subject to the provisions of subsections (a) and (b) of this section and the following guidelines:

(1) The aggregate actuarial value of the plan established as the benchmark plan should be considered as a targeted maximum or limitation in developing the benefits package;

(2) All estimated program and administrative costs, including incurred but not reported claims, shall not exceed ninety percent of the funding available to the program for the applicable fiscal year; and

(3) The state's interest in achieving health care services for all its children at less than two hundred percent of the federal poverty guideline shall take precedence over enhancing the benefits available under this program.

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

(e) The board shall meet no less than once each quarter to review implementation of its current financial plan and, using actuarial data, shall make those modifications to the plan that are necessary to ensure its fiscal stability and effectiveness of service. The board may not increase the types and levels of cost to families of covered children during its quarterly review except in the event of a true emergency. The board may not expand the population of children to whom the program is made available except in its annual plan: *Provided*, That upon the effective date of this article, the board may expand coverage to any child eligible under the provisions of Title XXI of the Social Security Act of 1997: *Provided, however*, That the board shall implement cost-sharing provisions for children who may qualify for such expanded coverage and whose family income exceeds one hundred fifty percent of the federal poverty guideline. Such cost-sharing provisions may be imposed through any one or a combination of the following: enrollment fees, premiums, copayments and deductibles.

(f) The board may develop and implement programs that provide for family coverage and/or employer subsidies within the limits authorized by the provisions of Title XXI of the Social Security Act of 1997 or the federal regulations promulgated thereunder: *Provided*, That any family health insurance coverage offered by or through the program shall be structured so that the board assumes no financial risk: *Provided, however*, That families covered by any insurance offered by or through the program shall be subject to cost-sharing provisions which may include, without limitation, enrollment fees, premiums, copayments and/or deductibles, as determined by the board, which shall be based on ability to pay: *Provided further*, That enrollment fees or premiums, if imposed, may be paid, in whole or in part, through employer subsidies or other private funds or public funds, subject to availability, all as allowed by applicable state and federal law.

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

§5-16B-6a. Coverage for patient cost of clinical trials.

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

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

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

member in a clinical trial, as a result of:

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

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

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

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

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

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

(A) One of the national institutes of health;

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

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

(D) The federal department of veterans affairs; or

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

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

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

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

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

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

(8) Reimbursement for treatment by an out of network or noncontracting provider shall be reimbursed at a rate which is no greater than that provided by an in network or contracting

provider. Coverage shall not be required if the out of network or noncontracting provider will not accept this level of reimbursement.

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

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

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

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

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

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

§5-16B-6b. Definitions.

For purposes of section six-a of this article:

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

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

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

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

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

(c) "Cooperative group" includes:

(1) The national cancer institute clinical cooperative group;

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

(3) The AIDS clinical trial group; and

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

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

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

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

(g) "Multiple project assurance contract" means a contract between an institution and the federal department of health and human services that defines the relationship of the institution to the federal department of health and human services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

(h) "NIH" means the national institutes of health.

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

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

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

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

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

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

(6) Adverse events during treatment are divided into those that reflect the natural history of the disease, or its progression, and those that are unique in the experimental treatment. Costs for the former are the responsibility of the payor as provided in section two of this article, and costs for the later are the responsibility of the sponsor. The sponsor shall hold harmless any payor for any

losses and injuries sustained by any member as a result of his or her participation in the clinical trial.

§5-16B-6c. Modified benefit plan for children of families of low income between two hundred and three hundred percent of the poverty level.

The Legislature finds:

- (1) That there exists a number of families of low to moderate income without access to affordable health insurance coverage, whose children are denied plan participation because their family income exceeds two hundred percent of the federal poverty level;
- (2) That this exclusion imposes a heavy burden on many families by forcing them to elect whether to spend money on their children's health care or for their food, clothing and educational needs;
- (3) That a plan should be developed and considered whereby children in families with an income between two hundred and three hundred percent of the federal poverty level would contribute approximately twenty to twenty-five percent of the actual cost of coverage resulting in no additional cost to state government; and
- (4) That, while the primary goal of any plan will be the improvement of health care for these children, a successful plan for extending this coverage will benefit the state by improving the economy by allowing parents of these children to spend more for goods and services and by lowering future medical expenditures, uncompensated care and the other long-term adverse economic effects related to having a segment of the adult population which has been deprived of adequate medical care during childhood.

The board is directed to conduct a study of all available means to develop a viable, modified plan to enroll the children of those families having a level of income between two hundred and three hundred percent of the federal poverty level and to consider that such a plan should charge an affordable premium and may be phased in over a two-year period.

The board is further directed to study total program costs related to the implementation of a viable modified plan to expand coverage with the design requiring no additional state dollars and to study the long-term effect on the state budget.

The board is directed to report its findings and recommendations to the Joint Committee on Government and Finance at its monthly meeting of August, two thousand four.

§5-16B-6d. Modified benefit plan implementation.

- (a) Upon approval by the Centers for Medicare and Medicaid Services, the board shall implement a program for uninsured children of families with income between two hundred and three hundred percent of the federal poverty level.
- (b) The benefit plans offered pursuant to this section shall include services determined to be appropriate for children, but may vary from those currently offered by the board.

(c) The board shall structure the benefit plans for this expansion to include premiums, coinsurance or copays and deductibles. The board shall develop the cost sharing features in such a manner as to keep the program fiscally stable without creating a barrier to enrollment. Such features may include different cost-sharing features within this group based upon the percentage of the federal poverty level.

(d) Children covered by an employer sponsored health insurance plan during the previous twelve month period are not eligible for coverage under this expansion, unless that coverage is lost due to the parent's loss of employment.

(e) Provider reimbursement schedules shall be no lower than the reimbursement provided for the same services under the plans offered in article sixteen of this chapter.

(f) All provisions of this article are applicable to this expansion unless expressly addressed in this section.

(g) Nothing in this section may be construed to require any appropriation of state general revenue funds for the payment of any benefit provided pursuant to this section, except for the state appropriation used to match the federal financial participation funds. In the event that federal funds are no longer authorized for participation by individuals eligible at income levels above two hundred percent, the board shall take immediate steps to terminate the expansion provided for in this section and notify all enrollees of such termination. In the event federal appropriations decrease for the programs created pursuant to Title XXI of the Social Security Act of 1997, the board is directed to make those decreases in this expansion program before making changes to the programs created for those children whose family income is less than two hundred percent of the federal poverty level.

(h) The board is directed to report no less than quarterly to the Legislative Oversight Commission on Health and Human Resources Accountability on the development, implementation and progress of the expansion authorized in this section.

§5-16B-7. West Virginia children's health fund.

(a) There is hereby created in the state treasury a special revolving fund to be known as the "West Virginia children's health fund", which shall be an interest-bearing account. All moneys deposited or accrued in this fund shall be used exclusively:

- (1) To provide the state's share of the children's health fund;
- (2) To cover administrative costs associated with the children's health program; and
- (3) To cover outreach activities.

(b) Moneys from the following sources may be placed into the fund:

- (1) All public funds appropriated by the Legislature or transferred by any public agency as contemplated or permitted by applicable federal program laws;

(2) All private moneys contributed by corporations, individuals or other entities to the fund as contemplated and permitted by applicable federal and state laws;

(3) Any accrued interest; and

(4) Federal financial participation matching the amounts referred to in subdivisions (1), (2) and

(3) of this subsection, in accordance with Section 1902 (a) (2) of the Social Security Act.

(c) Any balance remaining in the children's health fund at the end of any state fiscal year shall not revert to the state treasury but shall remain in this fund and shall be used only in a manner consistent with this article.

(d) Notwithstanding the provisions of section two, article two, chapter twelve of this code, funds of the West Virginia children's health fund may not be redesignated for any purpose other than those set forth in this subsection. All state and private moneys received by the program shall be deposited in the West Virginia consolidated investment pool with the West Virginia investment management board, with the interest income a proper credit to all such funds.

§5-16B-8. Termination and reauthorization.

(a) The program established in this article abrogates and shall be of no further force and effect, without further action by the Legislature, upon the occurrence of any of the following:

(1) The date of entry of a final judgment or order by a court of competent jurisdiction which disallows the program;

(2) The effective date of any reduction in annual federal funding levels below the amounts allocated and/or projected in Title XXI of the Social Security Act of 1997;

(3) The effective date of any federal rule or regulation negating the purposes or effect of this article; or

(4) For purposes of subdivisions (2) and (3) of this subsection, if a later effective date for such reduction or negation is specified, such date will control.

(b) Upon termination of the board and notwithstanding any provisions to the contrary, the director may change the levels of costs to covered families only in accordance with rules proposed to the Legislature pursuant to the provisions of chapter twenty-nine-a of this code.

§5-16B-9. Public-private partnerships.

The board and the director are authorized to work in conjunction with a nonprofit corporation organized pursuant to the corporate laws of the state, structured to permit qualification pursuant to section 501(c) of the Internal Revenue Code for purposes of assisting the children's health program and funded from sources other than the state or federal government. Members of the board may sit on the board of directors of the private nonprofit corporation.

§5-16B-10. Assignment of rights; right of subrogation by children's health insurance agency to the rights of recipients of medical assistance; rules as to effect of subrogation.

(a) Submission of an application to the children's health insurance agency for medical assistance is, as a matter of law, an assignment of the right of the applicant or legal representative thereof, to recovery from personal insurance or other sources, including, but not limited to, liable third parties, to the extent of the cost of children's health insurance agency services paid for by the children's health insurance agency program. This assignment of rights does not extend to medicare benefits. At the time the application is made, the children's health insurance agency shall include a statement along with the application that explains that the applicant has assigned his or her rights and the legal implications of making an assignment as provided in this section. If medical assistance is paid or will be paid to a provider of medical care on behalf of a recipient of medical assistance because of any sickness, injury, disease or disability, and another person is legally liable for the expense, either pursuant to contract, negligence or otherwise, the children's health insurance agency shall have a right to recover full reimbursement from any award or settlement for the medical assistance from the other person, or from the recipient of the assistance if he or she has been reimbursed by the other person. The children's health insurance agency shall be legally assigned the rights of the recipient against the person so liable, but only to the extent of the reasonable value of the medical assistance paid and attributable to the sickness, injury, disease or disability for which the recipient has received damages. When an action or claim is brought by a medical assistance recipient or by someone on his or her behalf against a third party who may be liable for the injury, disease, disability or death of a medical assistance recipient, any settlement, judgment or award obtained is subject to the claim of the children's health insurance agency for reimbursement of an amount sufficient to reimburse the children's health insurance agency the full amount of benefits paid on behalf of the recipient under the medical assistance program for the injury, disease, disability or death of the medical assistance recipient. The claim of the children's health insurance agency assigned by the recipient may not exceed the amount of medical expenses for the injury, disease, disability or death of the recipient paid by the children's health insurance agency on behalf of the recipient. The right of subrogation created in this section includes all portions of the cause of action, by either settlement, compromise, judgment or award, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to the subrogation. Any settlement, compromise, judgment or award that excludes or limits the cost of medical services or care does not preclude the children's health insurance agency from enforcing its rights under this section. The children's health insurance agency may compromise, settle and execute a release of any claim, in whole or in part.

(b) Nothing in this section shall be construed so as to prevent the recipient of medical assistance from maintaining an action for injuries received by them against any other person and from including therein, as part of the compensatory damages sought to be recovered, the amount or amounts of his or her medical expenses, even though the person received medical assistance in the payment of the medical expenses, in whole or in part.

If the action be tried by a jury, the jury is not to be informed as to the interest of the children's health insurance agency, if any, and the fact is not to be disclosed to the jury at any time. The trial judge shall, upon the entry of judgment on the verdict, direct that an amount equal to the amount of medical assistance given be withheld and paid over to the children's health insurance

agency. Irrespective of whether the case be terminated by judgment or by settlement without trial, from the amount required to be paid to the children's health insurance agency there shall be deducted the attorney fees attributable to the amount in accordance with and in proportion to the fee arrangement made between the recipient and his or her attorney of record so that the children's health insurance agency shall bear the pro rata portion of the attorney fees. Nothing in this section shall preclude any person who has received medical assistance from settling any cause of action which he or she may have against another person and delivering to the children's health insurance agency, from the proceeds of the settlement, the sums received by him or her from the children's health insurance agency or paid by the children's health insurance agency for his or her medical assistance. If the other person is aware of or has been informed of the interest of the children's health insurance agency in the matter, it shall be the duty of the person to whose benefit the release inures to withhold so much of the settlement as may be necessary to reimburse the children's health insurance agency to the extent of its interest in the settlement. No judgment, award of or settlement in any action or claim by a medical assistance recipient to recover damages for injuries, disease or disability, in which the children's health insurance agency has interest, shall be satisfied without first giving the children's health insurance agency notice and reasonable opportunity to establish its interest. The children's health insurance agency shall have sixty days from receipt of written notice to advise the recipient or his or her representative in writing of the children's health insurance agency's desire to establish its interest through the assignment. If no written intent is received within the sixty-day period, then the recipient may proceed and in the event of full recovery forward to the children's health insurance agency the portion of the recovery proceeds less the children's health insurance agency's share of attorney's fees and costs expended in the matter. In the event of less than full recovery the recipient and the children's health insurance agency shall agree as to the amount to be paid to the children's health insurance agency for its claim. If there is no recovery, the children's health insurance agency shall under no circumstances be liable for any costs or attorney's fees expended in the matter. If, after being notified in writing of a subrogation claim and possible liability of the recipient, guardian, attorney or personal representative for failure to subrogate the children's health insurance agency, a recipient, his or her guardian, attorney or personal representative disposes of the funds representing the judgment, settlement or award, without the written approval of the children's health insurance agency, that person shall be liable to the children's health insurance agency for any amount that, as a result of the disposition of the funds, is not recoverable by the children's health insurance agency. In the event that a controversy arises concerning the subrogation claims by the children's health insurance agency, an attorney shall interplead, pursuant to rule twenty-two of the rules of civil procedure, the portion of the recipient's settlement that will satisfy the children's health insurance agency exclusive of attorney's fees and costs regardless of any contractual arrangement between the client and the attorney.

(c) Nothing contained herein shall authorize the children's health insurance agency to institute a class action or multiple plaintiff action against any manufacturer, distributor or vendor of any product to recover children's health insurance agency care expenditures paid for by the children's health insurance agency program.