

WEST VIRGINIA LEGISLATURE

2021 REGULAR SESSION

Introduced

House Bill 2263

BY DELEGATES J. PACK, ROHRBACH, SUMMERS, G.

WARD, FORSHT, SMITH, AND WORRELL

[Introduced February 10, 2021; Referred to the
Committee on Health and Human Resources]

1 A BILL to amend and reenact 5-16-9 of the Code of West Virginia, 1931, as amended; to amend
2 and reenact §33-51-3, §33-51-8, and §33-51-9 of said code; and to amend said code by
3 adding thereto a new section, designated §33-51-11, all relating generally to the regulation
4 of pharmacy benefit managers; expanding certain definitions; regulating the
5 reimbursements of pharmacy benefit managers; providing certain effective dates; defining
6 certain methodologies utilized by pharmacy benefit managers; expanding the freedom of
7 consumer choice for pharmacies and pharmacy benefit managers; setting guidelines into
8 what pharmacy benefit plans may and may not do; and further explaining health benefit
9 plans.

Be it enacted by the Legislature of West Virginia:

**CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE
GOVERNOR, SECRETARY OF STATE, AND ATTORNEY GENERAL;
BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES,
COMMISSIONS, OFFICES, PROGRAMS, ETC.**

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

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

1 (a) The director is hereby given exclusive authorization to execute such contract or
2 contracts as are necessary to carry out the provisions of this article and to provide the plan or
3 plans of group hospital and surgical insurance coverage, group major medical insurance
4 coverage, group prescription drug insurance coverage, and group life and accidental death

5 insurance coverage selected in accordance with the provisions of this article, such contract or
6 contracts to be executed with one or more agencies, corporations, insurance companies or
7 service organizations licensed to sell group hospital and surgical insurance, group major medical
8 insurance, group prescription drug insurance and group life and accidental death insurance in this
9 state.

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

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

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

21 (3) A test for the human papilloma virus (HPV) for women age 18 or over, when medically
22 appropriate and consistent with the current guidelines from either the United States Preventive
23 Services Task Force or the American College of Obstetricians and Gynecologists for women age
24 18 and over;

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

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

29 (6) Coverage for general anesthesia for dental procedures and associated outpatient
30 hospital or ambulatory facility charges provided by appropriately licensed healthcare individuals

31 in conjunction with dental care if the covered person is:

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

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

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

50 (i) Immunoglobulin E and Nonimmunoglobulin E-medicated allergies to multiple food
51 proteins;

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

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

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

56 (B) The coverage required by §15-16-9(b)(7)(A) of this code shall include medical foods

57 for home use for which a physician has issued a prescription and has declared them to be
58 medically necessary, regardless of methodology of delivery.

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

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

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

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

71 (e) The provisions of §5A-3-1 *et seq.* of this code, relating to the Division of Purchasing of
72 the Department of Finance and Administration, shall not apply to any contracts for any insurance
73 coverage or professional services authorized to be executed under the provisions of this article.
74 Before entering into any contract for any insurance coverage, as authorized in this article, the
75 director shall invite competent bids from all qualified and licensed insurance companies or
76 carriers, who may wish to offer plans for the insurance coverage desired: *Provided*, That the
77 director shall negotiate and contract directly with healthcare providers and other entities,
78 organizations and vendors in order to secure competitive premiums, prices, and other financial
79 advantages. The director shall deal directly with insurers or healthcare providers and other
80 entities, organizations, and vendors in presenting specifications and receiving quotations for bid
81 purposes. No commission or finder’s fee, or any combination thereof, shall be paid to any
82 individual or agent; but this shall not preclude an underwriting insurance company or companies,

83 at their own expense, from appointing a licensed resident agent, within this state, to service the
84 companies' contracts awarded under the provisions of this article. Commissions reasonably
85 related to actual service rendered for the agent or agents may be paid by the underwriting
86 company or companies: *Provided, however,* That in no event shall payment be made to any agent
87 or agents when no actual services are rendered or performed. The director shall award the
88 contract or contracts on a competitive basis. In awarding the contract or contracts the director
89 shall take into account the experience of the offering agency, corporation, insurance company, or
90 service organization in the group hospital and surgical insurance field, group major medical
91 insurance field, group prescription drug field, and group life and accidental death insurance field,
92 and its facilities for the handling of claims. In evaluating these factors, the director may employ
93 the services of impartial, professional insurance analysts or actuaries or both. Any contract
94 executed by the director with a selected carrier shall be a contract to govern all eligible employees
95 subject to the provisions of this article. Nothing contained in this article shall prohibit any insurance
96 carrier from soliciting employees covered hereunder to purchase additional hospital and surgical,
97 major medical or life and accidental death insurance coverage.

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

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

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

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

120 (j) The director shall include language in all contracts for pharmacy benefits management,
121 as defined by §33-51-3 of this code, requiring the pharmacy benefit manager to report quarterly
122 to the agency ~~for all pharmacy claims the amount paid to the pharmacy provider per claim,~~
123 ~~including, but not limited to the following:~~

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

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

128 (3) The overall total number of claims in which the pharmacy benefits manager reimbursed
129 a pharmacy provider for less than the amount charged to the agency for all claims processed by
130 the pharmacy benefit manager during the quarter; and

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

133 ~~(4)~~ (A) The cost of drug reimbursement;

134 ~~(2)~~ (B) Dispensing fees;

135 ~~(3)~~ (C) Copayments; and

136 ~~(4)~~ (D) The amount charged to the agency for each claim by the pharmacy benefit
137 manager.

138 In the event there is a difference between ~~these amounts for any claim~~ the amount for any
139 pharmacy claim paid to the pharmacy provider and the amount reimbursed to the agency, the
140 pharmacy benefit manager shall report an itemization of all administrative fees, rebates, or
141 processing charges associated with the claim. All data and information provided by the pharmacy
142 benefit manager shall be kept secure, and notwithstanding any other provision of this code to the
143 contrary, the agency shall maintain the confidentiality of the proprietary information and not share
144 or disclose the proprietary information contained in the report or data collected with persons
145 outside the agency.

146 All data and information provided by the pharmacy benefit manager shall be considered
147 proprietary and confidential and exempt from disclosure under the West Virginia Freedom of
148 Information Act pursuant to §29B-1-4(a)(1) of this code. Only those agency employees involved
149 in collecting, securing, and analyzing the data for the purpose of preparing the report provided for
150 herein shall have access to the proprietary data. The director shall ~~using aggregated, non-~~
151 ~~proprietary data only, report at least quarterly to the Joint Committee on Government and Finance~~
152 ~~on the implementation of this subsection and its impact on program expenditures~~ provide a
153 quarterly report to the Joint Committee on Government and Finance and the Joint Committee on
154 Health detailing the information required by this section, including any difference or spread
155 between the overall amount paid by pharmacy benefit managers to the pharmacy providers and
156 the overall amount charged to the agency for each claim by the pharmacy benefit manager. To
157 the extent necessary, the director shall use aggregated, nonproprietary data only: *Provided, That*
158 the director must provide a clear and concise summary of the total amounts charged to the agency
159 and reimbursed to pharmacy providers on a quarterly basis.

160 (k) If the information required herein is not provided, the agency may terminate the contract

161 with the pharmacy benefit manager and the Office of the Insurance Commissioner shall discipline
162 the pharmacy benefit manager as provided in §33-51-8(e) of this code.

CHAPTER 33. INSURANCE

ARTICLE 51. PHARMACY AUDIT INTEGRITY ACT.

§33-51-3. Definitions.

1 For purposes of this article:

2 “340B entity” means an entity participating in the federal 340B drug discount program, as
3 described in 42 U.S.C. §256b, including its pharmacy or pharmacies, or any pharmacy or
4 pharmacies, contracted with the participating entity to dispense drugs purchased through such
5 program.

6 ~~“Affiliate” means a pharmacy, pharmacist, or pharmacy technician that directly or
7 indirectly, through one or more intermediaries, owns or controls, is owned or controlled by, or is
8 under common ownership or control with a pharmacy benefit manager~~

9 “Affiliate” means a pharmacy, pharmacist, or pharmacy technician which, either directly or
10 indirectly through one or more intermediaries: (A) Has an investment or ownership interest in a
11 pharmacy benefits manager licensed under this chapter; (B) shares common ownership with a
12 pharmacy benefits manager licensed under this chapter; or (C) has an investor or ownership
13 interest holder which is a pharmacy benefits manager licensed under this article.

14 “Auditing entity” means a person or company that performs a pharmacy audit, including a
15 covered entity, pharmacy benefits manager, managed care organization, or third-party
16 administrator.

17 “Business day” means any day of the week excluding Saturday, Sunday, and any legal
18 holiday as set forth in §2-2-1 of this code.

19 “Claim level information” means data submitted by a pharmacy or required by a payer or
20 claims processor to adjudicate a claim.

21 “Covered entity” means a contract holder or policy holder providing pharmacy benefits to
22 a covered individual under a health insurance policy pursuant to a contract administered by a
23 pharmacy benefits manager.

24 “Covered individual” means a member, participant, enrollee, or beneficiary of a covered
25 entity who is provided health coverage by a covered entity, including a dependent or other person
26 provided health coverage through the policy or contract of a covered individual.

27 “Extrapolation” means the practice of inferring a frequency of dollar amount of
28 overpayments, underpayments, nonvalid claims, or other errors on any portion of claims
29 submitted, based on the frequency of dollar amount of overpayments, underpayments, nonvalid
30 claims, or other errors actually measured in a sample of claims.

31 “Health care provider” has the same meaning as defined in §33-41-2 of this code.

32 “Health insurance policy” means a policy, subscriber contract, certificate, or plan that
33 provides prescription drug coverage. The term includes both comprehensive and limited benefit
34 health insurance policies.

35 “Health system” means a hospital or any other facility or entity owned, operated, or leased
36 by a hospital and a long-term care home.

37 “Insurance commissioner” or “commissioner” has the same meaning as defined in §33-1-
38 5 of this code.

39 “Network” means a pharmacy or group of pharmacies that agree to provide prescription
40 services to covered individuals on behalf of a covered entity or group of covered entities in
41 exchange for payment for its services by a pharmacy benefits manager or pharmacy services
42 administration organization. The term includes a pharmacy that generally dispenses outpatient
43 prescriptions to covered individuals or dispenses particular types of prescriptions, provides
44 pharmacy services to particular types of covered individuals or dispenses prescriptions in
45 particular health care settings, including networks of specialty, institutional or long-term care
46 facilities.

47 “Maximum allowable cost” means the per unit amount that a pharmacy benefits manager
48 reimburses a pharmacist for a prescription drug, excluding dispensing fees and copayments,
49 coinsurance, or other cost-sharing charges, if any.

50 “National average drug acquisition cost” means the monthly survey of retail pharmacies
51 conducted by the federal Centers for Medicare and Medicaid Services to determine average
52 acquisition cost for Medicaid covered outpatient drugs.

53 “Nonproprietary drug” means a drug containing any quantity of any controlled substance
54 or any drug which is required by any applicable federal or state law to be dispensed only by
55 prescription.

56 “Pharmacist” means an individual licensed by the West Virginia Board of Pharmacy to
57 engage in the practice of pharmacy.

58 “Pharmacy” means any place within this state where drugs are dispensed and pharmacist
59 care is provided.

60 “Pharmacy audit” means an audit, conducted on-site by or on behalf of an auditing entity
61 of any records of a pharmacy for prescription or nonproprietary drugs dispensed by a pharmacy
62 to a covered individual.

63 “Pharmacy benefits management” means the performance of any of the following:

64 (1) The procurement of prescription drugs at a negotiated contracted rate for dispensation
65 within the state of West Virginia to covered individuals;

66 (2) The administration or management of prescription drug benefits provided by a covered
67 entity for the benefit of covered individuals;

68 (3) The administration of pharmacy benefits, including:

69 (A) Operating a mail-service pharmacy;

70 (B) Claims processing;

71 (C) Managing a retail pharmacy network;

72 (D) Paying claims to a pharmacy for prescription drugs dispensed to covered individuals

73 via retail or mail-order pharmacy;

74 (E) Developing and managing a clinical formulary including utilization management and
75 quality assurance programs;

76 (F) Rebate contracting administration; and

77 (G) Managing a patient compliance, therapeutic intervention, and generic substitution
78 program.

79 “Pharmacy benefits manager” means a person, business, or other entity that performs
80 pharmacy benefits management for covered entities;

81 “Pharmacy record” means any record stored electronically or as a hard copy by a
82 pharmacy that relates to the provision of prescription or nonproprietary drugs or pharmacy
83 services or other component of pharmacist care that is included in the practice of pharmacy.

84 “Pharmacy services administration organization” means any entity that contracts with a
85 pharmacy to assist with third-party payer interactions and that may provide a variety of other
86 administrative services, including contracting with pharmacy benefits managers on behalf of
87 pharmacies and managing pharmacies’ claims payments from third-party payers.

88 “Point-of-sale fee” means all or a portion of a drug reimbursement to a pharmacy or other
89 dispenser withheld at the time of adjudication of a claim for any reason.

90 “Rebate” means any and all payments that accrue to a pharmacy benefits manager or its
91 health plan client, directly or indirectly, from a pharmaceutical manufacturer, including, but not
92 limited to, discounts, administration fees, credits, incentives, or penalties associated directly or
93 indirectly in any way with claims administered on behalf of a health plan client.

94 “Retroactive fee” means all or a portion of a drug reimbursement to a pharmacy or other
95 dispenser recouped or reduced following adjudication of a claim for any reason, except as
96 otherwise permissible as described in this article.

97 “Steering” means:

98 (A) Ordering an insured to use its affiliate pharmacy for the filling of a prescription or the

99 provision of pharmacy care;

100 (B) Ordering an insured to use an affiliate pharmacy of another pharmacy benefits
101 manager licensed under this chapter pursuant to an arrangement or agreement for the filling of a
102 prescription or the provision of pharmacy care;

103 (C) Offering or implementing plan designs that require an insured to utilize its affiliate
104 pharmacy or an affiliate pharmacy of another pharmacy benefits manager licensed under this
105 chapter or that increases plan or insured costs, including requiring an insured to pay the full cost
106 for a prescription when an insured chooses not to use any affiliate pharmacy; or

107 (D) Advertising, marketing, or promoting its affiliate pharmacy or an affiliate pharmacy of
108 another pharmacy benefits manager licensed under this chapter to insureds. Subject to the
109 foregoing, a pharmacy benefits manager may include its affiliated pharmacy or an affiliate
110 pharmacy of another pharmacy benefits manager licensed under this chapter in communications
111 to patients, including patient and prospective patient specific communications, regarding network
112 pharmacies and prices, provided that the pharmacy benefits manager includes information
113 regarding eligible nonaffiliated pharmacies in such communications and that the information
114 provided is accurate.

115 “Third party” means any insurer, health benefit plan for employees which provides a
116 pharmacy benefits plan, a participating public agency which provides a system of health insurance
117 for public employees, their dependents and retirees, or any other insurer or organization that
118 provides health coverage, benefits, or coverage of prescription drugs as part of workers’
119 compensation insurance in accordance with state or federal law. The term does not include an
120 insurer that provides coverage under a policy of casualty or property insurance.

§33-51-8. Licensure of pharmacy benefit managers.

1 (a) A person or organization may not establish or operate as a pharmacy benefits manager
2 in the state of West Virginia without first obtaining a license from the Insurance Commissioner
3 pursuant to this section: *Provided*, That a pharmacy benefit manager registered pursuant to §33-

4 5-7 of this code may continue to do business in the state until the Insurance Commissioner has
5 completed the legislative rule as set forth in §33-55-10 of this code: *Provided, however,* That
6 additionally the pharmacy benefit manager shall submit an application within six months of
7 completion of the final rule. The Insurance Commissioner shall make an application form available
8 on its publicly accessible internet website that includes a request for the following information:

9 (1) The identity, address, and telephone number of the applicant;

10 (2) The name, business address, and telephone number of the contact person for the
11 applicant;

12 (3) When applicable, the federal employer identification number for the applicant; and

13 (4) Any other information the Insurance Commissioner considers necessary and
14 appropriate to establish the qualifications to receive a license as a pharmacy benefit manager to
15 complete the licensure process, as set forth by legislative rule promulgated by the Insurance
16 Commissioner pursuant to §33-51-9(f) of this code.

17 (b) Term and fee. —

18 (1) The term of licensure shall be two years from the date of issuance.

19 (2) The Insurance Commissioner shall determine the amount of the initial application fee
20 and the renewal application fee for the registration. The fee shall be submitted by the applicant
21 with an application for registration. An initial application fee is nonrefundable. A renewal
22 application fee shall be returned if the renewal of the registration is not granted.

23 (3) The amount of the initial application fees and renewal application fees must be
24 sufficient to fund the Insurance Commissioner's duties in relation to his/her responsibilities under
25 this section, but a single fee may not exceed \$10,000.

26 (4) Each application for a license, and subsequent renewal for a license, shall be
27 accompanied by evidence of financial responsibility in an amount of \$1 million.

28 (c) Licensure. —

29 (1) The Insurance Commissioner shall propose legislative rules, in accordance with §33-

30 51-9(f) of this code, establishing the licensing, fees, application, financial standards, and reporting
31 requirements of pharmacy benefit managers.

32 (2) Upon receipt of a completed application, evidence of financial responsibility, and fee,
33 the Insurance Commissioner shall make a review of each applicant and shall issue a license if
34 the applicant is qualified in accordance with the provisions of this section and the rules
35 promulgated by the Insurance Commissioner pursuant to this section. The commissioner may
36 require additional information or submissions from an applicant and may obtain any documents
37 or information reasonably necessary to verify the information contained in the application.

38 (3) The license may be in paper or electronic form, is nontransferable, and shall
39 prominently list the expiration date of the license.

40 (d) Network adequacy. —

41 (1) A pharmacy benefit manager's network shall not be comprised only of mail-order
42 benefits but must have a mix of mail-order benefits and physical stores in this state.

43 (2) A pharmacy benefit manager shall provide a pharmacy benefit manager's network
44 report describing the pharmacy benefit manager's network and the mix of mail-order to physical
45 stores in this state in a time and manner required by rule issued by the Insurance Commissioner
46 pursuant to this section.

47 (3) Failure to provide a timely report may result in the suspension or revocation of a
48 pharmacy benefit manager's license by the Insurance Commissioner.

49 (e) Enforcement. —

50 (1) The Insurance Commissioner shall enforce this section and may examine or audit the
51 books and records of a pharmacy benefit manager providing pharmacy benefits management to
52 determine if the pharmacy benefit manager is in compliance with this section: *Provided*, That any
53 information or data acquired during the examination or audit is considered proprietary and
54 confidential and exempt from disclosure under the West Virginia Freedom of Information Act
55 pursuant to §29B-1-4(a)(1) of this code.

56 (2) The Insurance Commissioner may propose rules for legislative approval in accordance
57 with §29A-3-1 *et seq.* of this code regulating pharmacy benefit managers in a manner consistent
58 with this chapter. Rules adopted pursuant to this section shall set forth penalties or fines,
59 including, without limitation, monetary fines, suspension of licensure, and revocation of licensure
60 for violations of this chapter and the rules adopted pursuant to this section.

61 (f) Applicability. —

62 ~~(4)~~ This section is applicable to any contract or health benefit plan issued, renewed,
63 recredentialed, amended, or extended on or after July 1, 2019.

64 ~~(2) The requirements of this section, and any rules promulgated by the Insurance~~
65 ~~Commissioner pursuant to §33-51-9(f) of this code, do not apply to the coverage of prescription~~
66 ~~drugs under a plan that is subject to the Employee Retirement Income Security Act of 1974 or~~
67 ~~any information relating to such coverage~~

§33-51-9. Regulation of pharmacy benefit managers.

1 (a) A pharmacy, a pharmacist, and a pharmacy technician shall have the right to provide
2 a covered individual with information related to lower cost alternatives and cost share for the
3 covered individual to assist health care consumers in making informed decisions. Neither a
4 pharmacy, a pharmacist, nor a pharmacy technician may be penalized by a pharmacy benefit
5 manager for discussing information in this section or for selling a lower cost alternative to a
6 covered individual, if one is available, without using a health insurance policy.

7 (b) A pharmacy benefit manager may not collect from a pharmacy, a pharmacist, or a
8 pharmacy technician a cost share charged to a covered individual that exceeds the total submitted
9 charges by the pharmacy or pharmacist to the pharmacy benefit manager.

10 (c) A pharmacy benefit manager may only directly or indirectly charge or hold a pharmacy,
11 a pharmacist, or a pharmacy technician responsible for a fee related to the adjudication of a claim
12 if:

13 (1) The total amount of the fee is identified, reported, and specifically explained for each

14 line item on the remittance advice of the adjudicated claim; or

15 (2) The total amount of the fee is apparent at the point of sale and not adjusted between
16 the point of sale and the issuance of the remittance advice.

17 (d) A pharmacy benefit manager, or any other third party, that reimburses a 340B entity
18 for drugs that are subject to an agreement under 42 U.S.C. §256b shall not reimburse the 340B
19 entity for pharmacy-dispensed drugs at a rate lower than that paid for the same drug to
20 pharmacies similar in prescription volume that are not 340B entities, and shall not assess any fee,
21 charge-back, or other adjustment upon the 340B entity on the basis that the 340B entity
22 participates in the program set forth in 42 U.S.C. §256b.

23 (e) With respect to a patient eligible to receive drugs subject to an agreement under 42
24 U.S.C. §256b, a pharmacy benefit manager, or any other third party that makes payment for such
25 drugs, shall not discriminate against a 340B entity in a manner that prevents or interferes with the
26 patient's choice to receive such drugs from the 340B entity: *Provided*, That for purposes of this
27 section, "third party" does not include the state Medicaid program when Medicaid is providing
28 reimbursement for covered outpatient drugs, as that term is defined in 42 U.S.C. §1396r-8(k), on
29 a fee-for-service basis: *Provided, however*, That "third party" does include a Medicaid-managed
30 care organization as described in 42 U.S.C. §1396b(m).

31 ~~(f) This section does not apply with respect to claims under an employee benefit plan~~
32 ~~under the Employee Retirement Income Security Act of 1974 or, except for paragraph (d), to~~
33 ~~Medicare Part D.~~

34 (f) A pharmacy benefit manager may not reimburse a pharmacy or pharmacist for a
35 prescription drug or pharmacy service in an amount less than the national average drug
36 acquisition cost for the prescription drug or pharmacy service at the time the drug is administered
37 or dispensed, plus a professional dispensing fee of \$10.49: *Provided*, That if the national average
38 drug acquisition cost is not available at the time a drug is administered or dispensed, a pharmacy
39 benefit manager may not reimburse in an amount that is less than the wholesale acquisition cost

40 of the drug, as defined in 42 U.S.C. 1395w-3a(c)(6)(B), plus a provisional dispensing fee of
41 \$10.49.

42 (g) A pharmacy benefit manager may not reimburse a pharmacy or pharmacist for a
43 prescription drug or pharmacy service in an amount less than the amount the pharmacy benefit
44 manager reimburses itself or an affiliate for the same prescription drug or pharmacy service.

45 (h) The commissioner may order reimbursement to an insured, pharmacy, or dispenser
46 who has incurred a monetary loss as a result of a violation of this article or legislative rules
47 implemented pursuant to this article.

48 (i) (1) Any methodologies utilized by a pharmacy benefits manager in connection with
49 reimbursement shall be filed with the commissioner for use in determining maximum allowable
50 cost appeals. The methodologies are not subject to disclosure and shall be treated as confidential.

51 (2) A pharmacy benefits manager shall utilize the national average drug acquisition cost
52 as a point of reference for the ingredient drug product component of a pharmacy's reimbursement
53 for drugs appearing on the national average drug acquisition cost list and shall produce a report
54 every four months, which shall be provided to the commissioner and published by the pharmacy
55 benefits manager on a website available to the public for no less than 24 months, of all drugs
56 appearing on the national average drug acquisition cost list reimbursed 10 percent and below the
57 national average drug acquisition cost, as well as all drugs reimbursed 10 percent and above the
58 national average drug acquisition cost. For each drug in the report, a pharmacy benefits manager
59 shall include the month the drug was dispensed, the quantity of the drug dispensed, the amount
60 the pharmacy was reimbursed per unit or dosage, whether the dispensing pharmacy was an
61 affiliate, whether the drug was dispensed pursuant to a government health plan, and the average
62 national average drug acquisition cost for the month the drug was dispensed. The report shall
63 exclude drugs dispensed pursuant to 42 U.S.C. 256b.

64 (3) This subsection shall take effect on January 1, 2022;

65 (i) On and after July 1, 2022, a pharmacy benefits manager may not:

66 (1) Discriminate in reimbursement, assess any fees or adjustments, or exclude a
67 pharmacy from the pharmacy benefit manager's network on the basis that the pharmacy
68 dispenses drugs subject to an agreement under 42 U.S.C. 256b; or

69 (2) Engage in any practice that:

70 (A) In any way bases pharmacy reimbursement for a drug on patient outcomes, scores,
71 or metrics. This does not prohibit pharmacy reimbursement for pharmacy care, including
72 dispensing fees from being based on patient outcomes, scores, or metrics so long as the patient
73 outcomes, scores, or metrics are disclosed to and agreed to by the pharmacy in advance;

74 (B) Includes imposing a point-of-sale fee or retroactive fee; or

75 (C) Derives any revenue from a pharmacy or insured in connection with performing
76 pharmacy benefits management services: *Provided*, That this may not be construed to prohibit
77 pharmacy benefits managers from receiving deductibles or copayments.

78 (k) A pharmacy benefits manager shall offer a health plan the ability to receive 100 percent
79 of all rebates it receives from pharmaceutical manufacturers. In addition, a pharmacy benefits
80 manager shall report annually to each client, including, but not limited to, insurers and payors,
81 health plan and the department the aggregate amount of all rebates and other payments that the
82 pharmacy benefits manager received from pharmaceutical manufacturers in connection with
83 claims if administered on behalf of the client and the aggregate amount of such rebates the
84 pharmacy benefits manager received from pharmaceutical manufacturers that it did not pass
85 through to the client health plan.

86 (l) A pharmacy benefits manager shall offer a health plan the option of charging such
87 health plan the same price for a prescription drug as it pays a pharmacy for the prescription drug:
88 *Provided*, That a pharmacy benefits manager shall charge a health benefit plan administered by
89 or on behalf of the state or a political subdivision of the state, the same price for a prescription
90 drug as it pays a pharmacy for the prescription drug.

91 (m) A pharmacy benefits manager shall report in the aggregate to a health plan the

92 difference between the amount the pharmacy benefits manager reimbursed a pharmacy and the
93 amount the pharmacy benefits manager charged a health plan.

§33-51-11. Freedom of consumer choice for pharmacy.

1 (a) A pharmacy benefits manager or health benefit plan may not:

2 (1) Prohibit or limit any covered individual from selecting a pharmacy or pharmacist of his
3 or her choice who has agreed to participate in the plan according to the terms offered by the
4 insurer;

5 (2) Deny a pharmacy or pharmacist the right to participate as a contract provider under
6 the policy or plan if the pharmacy or pharmacist agrees to provide pharmacy services, including,
7 but not limited to, prescription drugs, that meet the terms and requirements set forth by the insurer
8 under the policy or plan and agrees to the terms of reimbursement set forth by the insurer;

9 (3) Impose upon a beneficiary of pharmacy services under a health benefit plan any
10 copayment, fee or condition that is not equally imposed upon all beneficiaries in the same benefit
11 category, class or copayment level under the health benefit plan when receiving services from a
12 contract provider;

13 (4) Impose a monetary advantage or penalty under a health benefit plan that would affect
14 a beneficiary's choice among those pharmacies or pharmacists who have agreed to participate in
15 the plan according to the terms offered by the insurer. Monetary advantage or penalty includes
16 higher copayment, a reduction in reimbursement for services, or promotion of one participating
17 pharmacy over another by these methods;

18 (5) Reduce allowable reimbursement for pharmacy services to a beneficiary under a
19 health benefit plan because the beneficiary selects a pharmacy of his or her choice, so long as
20 that pharmacy has enrolled with the health benefit plan under the terms offered to all pharmacies
21 in the plan coverage area;

22 (6) Require a beneficiary, as a condition of payment or reimbursement, to purchase
23 pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy; or

24 (7) Impose upon a beneficiary any copayment, amount of reimbursement, number of days
25 of a drug supply for which reimbursement will be allowed, or any other payment or condition
26 relating to purchasing pharmacy services from any pharmacy, including prescription drugs, that
27 is more costly or more restrictive than that which would be imposed upon the beneficiary if such
28 services were purchased from a mail-order pharmacy or any other pharmacy that is willing to
29 provide the same services or products for the same cost and copayment as any mail order service.

30 (b) If a health benefit plan providing reimbursement to West Virginia residents for
31 prescription drugs restricts pharmacy participation, the entity providing the health benefit plan
32 shall notify, in writing, all pharmacies within the geographical coverage area of the health benefit
33 plan, and offer to the pharmacies the opportunity to participate in the health benefit plan at least
34 60 days prior to the effective date of the plan. All pharmacies in the geographical coverage area
35 of the plan shall be eligible to participate under identical reimbursement terms for providing
36 pharmacy services, including prescription drugs. The entity providing the health benefit plan shall,
37 through reasonable means, on a timely basis and on regular intervals, inform the beneficiaries of
38 the plan of the names and locations of pharmacies that are participating in the plan as providers
39 of pharmacy services and prescription drugs. Additionally, participating pharmacies shall be
40 entitled to announce their participation to their customers through a means acceptable to the
41 pharmacy and the entity providing the health benefit plans. The pharmacy notification provisions
42 of this section shall not apply when an individual or group is enrolled, but when the plan enters a
43 particular county of the state.

44 (c) The Insurance Commissioner shall not approve any pharmacy benefits manager or
45 health benefit plan providing pharmaceutical services which does not conform to this section.

46 (d) Any covered individual or pharmacy injured by a violation of this section may maintain
47 a cause of action to enjoin the continuance of any such violation.

48 (e) This section shall apply to all pharmacy benefits managers and health benefit plans
49 providing pharmaceutical services benefits, including prescription drugs, to any resident of West

50 Virginia. For purposes of this section, "health benefit plan" means any entity or program that
51 provides reimbursement for pharmaceutical services. This section shall also apply to insurance
52 companies and health maintenance organizations that provide or administer coverages and
53 benefits for prescription drugs. This section shall not apply to any entity that has its own facility,
54 employs or contracts with physicians, pharmacists, nurses and other health care personnel, and
55 that dispenses prescription drugs from its own pharmacy to its employees and dependents
56 enrolled in its health benefit plan; but this section shall apply to an entity otherwise excluded that
57 contracts with an outside pharmacy or group of pharmacies to provide prescription drugs and
58 services.

NOTE: The purpose of this bill is to update the regulation of pharmacy benefit managers, to expand certain definitions within the field, to regulate the reimbursements of pharmacy benefit managers, to provide certain effective dates, to define certain methodologies utilized by pharmacy benefit managers, to expand the freedom of consumer choice for pharmacies and pharmacy benefit managers, to set guidelines into what pharmacy benefit plans may and may not do, and to further explain health benefit plans.

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