

WEST VIRGINIA LEGISLATURE

2021 REGULAR SESSION

ENROLLED

Committee Substitute

for

House Bill 2263

BY DELEGATES J. PACK, ROHRBACH, SUMMERS, G.
WARD, FORSHT, SMITH, WORRELL, BATES AND WALKER
[Passed March 30, 2021; in effect ninety days from
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1 AN ACT to amend and reenact §5-16-9 of the Code of West Virginia, 1931, as amended; to amend
2 and reenact §33-51-2, §33-51-3, §33-51-8, and §33-51-9 of said code; and to amend said
3 code by adding thereto two new sections, designated §33-51-11 and §33-51-12, all
4 relating to the regulation of pharmacy benefit managers; updating the reporting
5 requirements related Public Employees Insurance Agency; expanding scope; defining
6 terms; regulating the reimbursements of pharmacy benefit managers; requiring a
7 adequate network; providing rulemaking authority; providing an effective date; requiring
8 filing of certain methodologies utilized by pharmacy benefit managers; prohibiting certain
9 practices by pharmacy benefits managers; providing consumer choice for pharmacies;
10 setting guidelines for pharmacy benefit plans; requiring rebates to be passed down;
11 requiring reporting; and requiring the commissioner to consider information in reviewing
12 rates.

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 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
11 in connection with mammogram and pap smears when performed for cancer screening or
12 diagnostic services and annual checkups for prostate cancer in men age 50 and over. Such
13 benefits shall 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
30 in 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
35 general 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
38 be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss
39 of 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,
43 and that is subject to this section, shall provide coverage, through the age of 20, for amino acid-
44 based formula for the treatment of severe protein-allergic conditions or impaired absorption of
45 nutrients 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-medicated 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

65 of \$10,000 for every employee. The amount of the group life and accidental death insurance to

66 which 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) The provisions of §5A-3-1 *et seq.* of this code, relating to the Division of Purchasing of

71 the Department of Finance and Administration, shall not apply to any contracts for any insurance

72 coverage or professional services authorized to be executed under the provisions of this article.

73 Before entering into any contract for any insurance coverage, as authorized in this article, the

74 director shall invite competent bids from all qualified and licensed insurance companies or

75 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
88 shall 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
92 the services of impartial, professional insurance analysts or actuaries or both. Any contract
93 executed by the director with a selected carrier shall be a contract to govern all eligible employees
94 subject to the provisions of this article. Nothing contained in this article shall prohibit any insurance
95 carrier from soliciting employees covered hereunder to purchase additional hospital and surgical,
96 major medical or life and accidental death insurance coverage.

97 (f) 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) 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) The director may at the end of any contract period discontinue any contract or contracts
106 it has executed with any carrier and replace the same with a contract or contracts with any other
107 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) The director shall include language in all contracts for pharmacy benefits management,
120 as defined by §33-51-3 of this code, requiring the pharmacy benefit manager to report quarterly
121 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
137 shall report an itemization of all administrative fees, rebates, or processing charges associated
138 with the claim. All data and information provided by the pharmacy benefit manager shall be kept
139 secure, and notwithstanding any other provision of this code to the contrary, the agency shall
140 maintain the confidentiality of the proprietary information and not share or disclose the proprietary
141 information contained in the report or data collected with persons outside the agency. All data
142 and information provided by the pharmacy benefit manager shall be considered proprietary and
143 confidential and exempt from disclosure under the West Virginia Freedom of Information Act
144 pursuant to §29B-1-4(a)(1) of this code. Only those agency employees involved in collecting,
145 securing, and analyzing the data for the purpose of preparing the report provided for herein shall
146 have access to the proprietary data. The director shall provide a quarterly report to the Joint
147 Committee on Government and Finance and the Joint Committee on Health detailing the
148 information required by this section, including any difference or spread between the overall
149 amount paid by pharmacy benefit managers to the pharmacy providers and the overall amount
150 charged to the agency for each claim by the pharmacy benefit manager. To the extent necessary,
151 the director shall use aggregated, nonproprietary data only: *Provided*, That the director must
152 provide a clear and concise summary of the total amounts charged to the agency and reimbursed
153 to pharmacy providers on a quarterly basis.

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

CHAPTER 33. INSURANCE

ARTICLE 51. REGULATION OF PHARMACY AUDITING ENTITIES AND PHARMACY BENEFIT MANAGERS.

§33-51-2. Scope.

1 This article covers any audit of the records of a pharmacy conducted by a managed care
2 company, third-party payer, pharmacy benefits manager or an entity that represents a covered
3 entity, or health benefit plan, the registration of auditing entities, and the licensure and regulation
4 of pharmacy benefits managers.

§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 which, either directly or
7 indirectly through one or more intermediaries: (A) Has an investment or ownership interest in a
8 pharmacy benefits manager licensed under this chapter; (B) shares common ownership with a
9 pharmacy benefits manager licensed under this chapter; or (C) has an investor or ownership
10 interest holder which is a pharmacy benefits manager licensed under this article.

11 "Auditing entity" means a person or company that performs a pharmacy audit, including a
12 covered entity, pharmacy benefits manager, managed care organization, or third-party
13 administrator.

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

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

18 “Covered entity” means a contract holder or policy holder providing pharmacy benefits to
19 a covered individual under a health insurance policy pursuant to a contract administered by a
20 pharmacy benefits manager and may include a health benefit plan.

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

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

28 “Defined cost sharing” means a deductible payment or coinsurance amount imposed on
29 an enrollee for a covered prescription drug under the enrollee’s health plan.

30 “Health benefit plan” or “health plan” means a policy, contract, certificate, or agreement
31 entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or
32 reimburse any of the costs of health care services.

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

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

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 “Third party” means any insurer, health benefit plan for employees which provides a
98 pharmacy benefits plan, a participating public agency which provides a system of health insurance
99 for public employees, their dependents and retirees, or any other insurer or organization that
100 provides health coverage, benefits, or coverage of prescription drugs as part of workers’
101 compensation insurance in accordance with state or federal law. The term does not include an
102 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 §33-51-10 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 51-10 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 be reasonably adequate, shall provide
42 for convenient patient access to pharmacies within a reasonable distance from a patient's
43 residence and shall not be comprised only of mail-order benefits but must have a mix of mail-
44 order benefits and physical stores in this state.

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

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

51 (e) Enforcement. —

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

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

63 (f) Applicability. —

64 This section is applicable to any contract or health benefit plan issued, renewed,
65 recredentialed, amended, or extended on or after July 1, 2019.

§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) A pharmacy benefit manager may not reimburse a pharmacy or pharmacist for a
32 prescription drug or pharmacy service in an amount less than the national average drug
33 acquisition cost for the prescription drug or pharmacy service at the time the drug is administered
34 or dispensed, plus a professional dispensing fee of \$10.49: *Provided*, That if the national average
35 drug acquisition cost is not available at the time a drug is administered or dispensed, a pharmacy
36 benefit manager may not reimburse in an amount that is less than the wholesale acquisition cost
37 of the drug, as defined in 42 U.S.C. § 1395w-3a(c)(6)(B), plus a professional dispensing fee of
38 \$10.49.

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

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

45 (i) (1) Any methodologies utilized by a pharmacy benefits manager in connection with
46 reimbursement shall be filed with the commissioner at the time of initial licensure and at any time
47 thereafter that the methodology is changed by the pharmacy benefit manager for use in
48 determining maximum allowable cost appeals. The methodologies are not subject to disclosure

49 and shall be treated as confidential and exempt from disclosure under the West Virginia Freedom
50 of Information Act §29B-1-4(a)(1) of this code.

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,

54 (j) A pharmacy benefits manager may not:

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

58 (2) Engage in any practice that:

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

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

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

67 (k) A pharmacy benefits manager shall offer a health plan the option of charging such
68 health plan the same price for a prescription drug as it pays a pharmacy for the prescription drug:
69 *Provided*, That a pharmacy benefits manager shall charge a health benefit plan administered by
70 or on behalf of the state or a political subdivision of the state, the same price for a prescription
71 drug as it pays a pharmacy for the prescription drug.

72 (l) A covered individual's defined cost sharing for each prescription drug shall be
73 calculated at the point of sale based on a price that is reduced by an amount equal to at least
74 100% of all rebates received, or to be received, in connection with the dispensing or administration

75 of the prescription drug. Any rebate over and above the defined cost sharing would then be
76 passed on to the health plan to reduce premiums. Nothing precludes an insurer from decreasing
77 a covered individual's defined cost sharing by an amount greater than what is previously stated.
78 The Commissioner may propose a legislative rule or by policy effectuate the provisions of this
79 subsection. Notwithstanding any other effective date to the contrary, the amendments to this
80 article enacted during the 2021 regular legislative session shall apply to all policies, contracts,
81 plans, or agreements subject to this section that are delivered, executed, amended, adjusted, or
82 renewed on or after January 1, 2022.

83 (m) This section is effective for policy, contract, plans, or agreements beginning on or after
84 January 1, 2022. This section applies to all policies, contracts, plans, or agreements subject to
85 this section that are delivered, executed, amended, adjusted, or renewed on or after the effective
86 date of this section.

§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 do 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.

§33-51-12. Reporting requirements.

1 (a) A pharmacy benefits manager shall report to the commissioner on an annual basis, or
2 more often as the commissioner deems necessary, for each health plan or covered entity the
3 following information:

4 (1) The aggregate amount of rebates received by the pharmacy benefits manager;

5 (2) The aggregate amount of rebates distributed to each health plan or covered entity
6 contracted with the pharmacy benefits manager;

7 (3) The aggregate amount of rebates passed on to the enrollees of each health plan or
8 covered entity at the point of sale that reduced the enrollees applicable deductible, copayment,
9 coinsurance, or other cost-sharing amount;

10 (4) The individual and aggregate amount paid by the health plan or covered entity to the
11 pharmacy benefits manager for pharmacist services itemized by pharmacy, by product, and by
12 goods and services; and

13 (5) The individual and aggregate amount a pharmacy benefits manager paid for
14 pharmacist services itemized by pharmacy, by product, and by goods and services.

15 (b) A pharmacy benefits manager shall annually report in the aggregate to the
16 commissioner and to a health plan or covered entity the difference between the amount the
17 pharmacy benefits manager reimbursed a pharmacy and the amount the pharmacy benefits
18 manager charged a health plan.

19 (c) A health benefit plan or covered entity shall annually report to the commissioner the
20 aggregate amount of credits, rebates, discounts, or other such payments received by the health
21 benefit plan or covered entity from a pharmacy benefits manager or drug manufacturer and
22 disclose whether or not those credits, rebates, discounts or other such payments were passed on
23 to reduce insurance premiums or rates. The commissioner shall consider the information in this
24 report in reviewing any premium rates charged for any individual or group accident and health
25 insurance policy as set forth in §33-6-9(e), §33-24-6(c), and §33-25A-8 of this code.

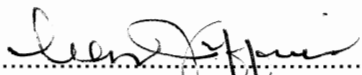
26 (d) A pharmacy benefits manager shall produce a quarterly report to the commissioner of
27 all drugs appearing on the national average drug acquisition cost list reimbursed 10 percent and
28 below the national average drug acquisition cost, as well as all drugs reimbursed 10 percent and
29 above the national average drug acquisition cost. For each drug in the report, a pharmacy
30 benefits manager shall include the month the drug was dispensed, the quantity of the drug

31 dispensed, the amount the pharmacy was reimbursed, whether the dispensing pharmacy was an
32 affiliate of the pharmacy benefits manager, whether the drug was dispensed pursuant to a
33 government health plan, and the average national drug acquisition cost for the month the drug
34 was dispensed. The report shall exclude drugs dispensed pursuant to 42 U.S.C. § 256b. A copy
35 of this report shall also be published on the pharmacy benefits manager's publicly available
36 website for a period of at least 24 months. This report is exempt from the confidentiality provisions
37 of subsection (f).

38 (e) The reports shall be filed electronically on a form and manner as prescribed by the
39 commissioner pursuant to a legitimate rule promulgated by the commissioner.

40 (f) With the exception of the quarterly report noted in subsection (d) of this section all data
41 and information provided by the pharmacy benefits manager, health plan, or covered entity
42 pursuant to these established reporting requirements shall be considered proprietary and
43 confidential and exempt from disclosure under the West Virginia Freedom of Information Act
44 §29B-1-4(a)(1) of this code.

The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.



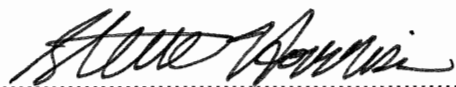
Chairman, House Committee




Chairman, Senate Committee

Originating in the House.

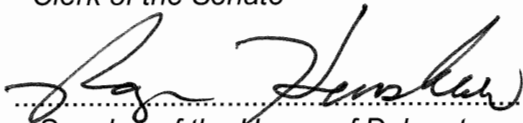
In effect ninety days from passage.



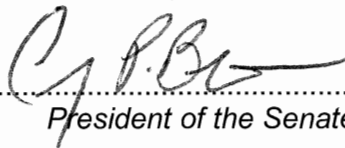
Clerk of the House of Delegates



Clerk of the Senate



Speaker of the House of Delegates



President of the Senate

The within is approved this the 9th
day of April 2021.


Governor

PRESENTED TO THE GOVERNOR

APR 05 2021

Time 10:16am