

# **WEST VIRGINIA LEGISLATURE**

## **2023 REGULAR SESSION**

**Introduced**

### **Senate Bill 557**

By Senator Maroney

[Introduced February 03, 2023; referred  
to the Committee on Health and Human Resources]

1 A BILL to amend and reenact §33-51-9 and §33-51-12 of the Code of West Virginia, 1931, as  
2 amended, all relating to reimbursement of prescription drug or pharmacy services;  
3 providing that a pharmacy or pharmacist may decline to dispense a prescription drug or  
4 pharmacy service where reimbursement by a public employees insurance program is less  
5 than the pharmacy or pharmacist's drug acquisition cost; and providing reporting by a  
6 pharmacy benefit manager to the insurance commissioner of the number of prescription  
7 drug or pharmacy services declined on an annual basis.

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

## **ARTICLE 51. PHARMACY AUDIT INTEGRITY ACT.**

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

1 (a) A pharmacy, a pharmacist, and a pharmacy technician shall have the right to provide a  
2 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 that reimburses a 340B entity for drugs that are subject to  
11 an agreement under 42 U.S.C. § 256b shall not reimburse the 340B entity for pharmacy-  
12 dispensed drugs at a rate lower than that paid for the same drug to pharmacies similar in  
13 prescription volume that are not 340B entities, and shall not assess any fee, charge-back, or other  
14 adjustment upon the 340B entity on the basis that the 340B entity participates in the program set  
15 forth in 42 U.S.C. §256b. For purposes of this subsection, the term "other adjustment" includes  
16 placing any additional requirements, restrictions, or unnecessary burdens upon the 340B entity

17 that results in administrative costs or fees to the 340B entity that are not placed upon other  
18 pharmacies that do not participate in the 340B program, including affiliate pharmacies of the  
19 pharmacy benefit manager, and further includes but is not limited to requiring a claim for a drug to  
20 include a modifier or be processed or resubmitted to indicate that the drug is a 340B drug:  
21 *Provided*, That nothing in this subsection shall be construed to prohibit the Medicaid program or a  
22 Medicaid managed care organization as described in 42 U.S.C. § 1396b(m) from preventing  
23 duplicate discounts as described in 42 U.S.C. 256b(a)(5)(A)(i). The provisions of this subsection  
24 are applicable to the West Virginia Public Employees Insurance Agency.

25 (d) With respect to a patient eligible to receive drugs subject to an agreement under 42  
26 U.S.C. § 256b, a pharmacy benefit manager shall not discriminate against a 340B entity in a  
27 manner that prevents or interferes with the patient's choice to receive such drugs from the 340B  
28 entity: *Provided*, That this section, does not apply to the state Medicaid program when Medicaid is  
29 providing reimbursement for covered outpatient drugs, as that term is defined in 42 U.S.C. §1396r-  
30 8(k), on a fee-for-service basis: *Provided, however*, That this subsection does apply to a Medicaid-  
31 managed care organization as described in 42 U.S.C. § 1396b(m). For purposes of this  
32 subsection, it shall be considered a discriminatory practice that prevents or interferes with a  
33 patient's choice to receive drugs at a 340B entity if a pharmacy benefit manager places additional  
34 requirements, restrictions or unnecessary burdens upon a 340B entity that results in  
35 administrative costs or fees to the 340B entity that are not placed upon other pharmacies that do  
36 not participate in the 340B program, including affiliate pharmacies of the pharmacy benefit  
37 manager or any other third-party, and further includes but is not limited to requiring a claim for a  
38 drug to include a modifier or be processed or resubmitted to indicate that the drug is a 340B drug:  
39 *Provided* further, That nothing in this subsection shall be construed to prohibit the Medicaid  
40 program or a Medicaid managed care organization as described in 42 U.S.C. § 1396b(m) from  
41 preventing duplicate discounts as described in 42 U.S.C. 256b(a)(5)(A)(i). The provisions of this  
42 subsection are applicable to the West Virginia Public Employees Insurance Agency.

43 (e) A pharmacy benefit manager may not reimburse a pharmacy or pharmacist for a  
44 prescription drug or pharmacy service in an amount less than the national average drug  
45 acquisition cost for the prescription drug or pharmacy service at the time the drug is administered  
46 or dispensed, plus a professional dispensing fee of \$10.49: *Provided*, That if the national average  
47 drug acquisition cost is not available at the time a drug is administered or dispensed, a pharmacy  
48 benefit manager may not reimburse in an amount that is less than the wholesale acquisition cost of  
49 the drug, as defined in 42 U.S.C. § 1395w-3a(c)(6)(B), plus a professional dispensing fee of  
50 \$10.49.

51 (f) A pharmacy benefit manager may not reimburse a pharmacy or pharmacist for a  
52 prescription drug or pharmacy service in an amount less than the amount the pharmacy benefit  
53 manager reimburses itself or an affiliate for the same prescription drug or pharmacy service.

54 (g) The commissioner may order reimbursement to an insured, pharmacy, or dispenser  
55 who has incurred a monetary loss as a result of a violation of this article or legislative rules  
56 implemented pursuant to this article.

57 (h) (1) Any methodologies utilized by a pharmacy benefits manager in connection with  
58 reimbursement shall be filed with the commissioner at the time of initial licensure and at any time  
59 thereafter that the methodology is changed by the pharmacy benefit manager for use in  
60 determining maximum allowable cost appeals. The methodologies are not subject to disclosure  
61 and shall be treated as confidential and exempt from disclosure under the West Virginia Freedom  
62 of Information Act §29B-1-4(a)(1) of this code. The filed methodologies shall comply with the  
63 provisions of §33-51-9(e) of this code, and a pharmacy benefits manager shall not enter into a  
64 contract with a pharmacy that provides for reimbursement methodology not permissible under the  
65 provisions of §33-51-9(e) of this code.

66 (2) For purposes of complying with the provisions of §33-51-9(e) of this code, a pharmacy  
67 benefits manager shall utilize the most recently published monthly national average drug

68 acquisition cost as a point of reference for the ingredient drug product component of a pharmacy's  
69 reimbursement for drugs appearing on the national average drug acquisition cost list; and,

70 (i) A pharmacy benefits manager may not:

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

74 (2) Engage in any practice that:

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

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

80 (C) Derives any revenue from a pharmacy or insured in connection with performing  
81 pharmacy benefits management services: *Provided*, That this may not be construed to prohibit  
82 pharmacy benefits managers from processing deductibles or copayments as have been approved  
83 by a covered individual's health benefit plan.

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

89 (k) A covered individual's defined cost sharing for each prescription drug shall be  
90 calculated at the point of sale based on a price that is reduced by an amount equal to at least 100  
91 percent of all rebates received, or to be received, in connection with the dispensing or  
92 administration of the prescription drug. Any rebate over and above the defined cost sharing would  
93 then be passed on to the health plan to reduce premiums. Nothing precludes an insurer from

94 decreasing a covered individual's defined cost sharing by an amount greater than what is  
 95 previously stated. The commissioner may propose a legislative rule or by policy effectuate the  
 96 provisions of this subsection.

97 (l) If the amount reimbursed to a pharmacy or pharmacist by a pharmacy benefit manager  
 98 under a health benefit plan administered by or on behalf of the state or a political subdivision of the  
 99 state, including the West Virginia Public Employees Insurance Agency, is different from the  
 100 reimbursement required by §33-51-9(e) of this code, then the pharmacy or pharmacist may  
 101 decline to dispense a prescription drug or to provide a pharmacy service if the reimbursement is  
 102 less than the pharmacy or pharmacist's acquisition cost for the same prescription drug or  
 103 pharmacy service: *Provided*, That a pharmacy or pharmacist declining to provide such drug  
 104 service shall provide the covered individual with adequate information as to where the prescription  
 105 drug or pharmacy service may be filled.

**§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) For each health benefit plan administered by or on behalf of the state or a political  
20 subdivision of the state, including the West Virginia Public Employees Insurance Agency, a  
21 pharmacy benefits manager shall annually report in the aggregate to the commissioner the  
22 number of times a pharmacy or pharmacist declines to dispense a prescription drug or pharmacy  
23 service pursuant to §33-51-9(l) of this code.

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

31 ~~(d)~~ (e) A pharmacy benefits manager shall produce a quarterly report to the commissioner  
32 of all drugs appearing on the national average drug acquisition cost list reimbursed 10 percent and  
33 below the national average drug acquisition cost, as well as all drugs reimbursed 10 percent and  
34 above the national average drug acquisition cost. For each drug in the report, a pharmacy benefits  
35 manager shall include the month the drug was dispensed, the quantity of the drug dispensed, the  
36 amount the pharmacy was reimbursed, whether the dispensing pharmacy was an affiliate of the  
37 pharmacy benefits manager, whether the drug was dispensed pursuant to a government health  
38 plan, and the average national drug acquisition cost for the month the drug was dispensed. The  
39 report shall exclude drugs dispensed pursuant to 42 U.S.C. § 256b. A copy of this report shall also

40 be published on the pharmacy benefits manager's publicly available website for a period of at least  
41 24 months. This report is exempt from the confidentiality provisions of subsection ~~(f)~~ (g).

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

44 ~~(f)~~ (g) With the exception of the quarterly report noted in subsection ~~(d)~~ (e) of this section all  
45 data and information provided by the pharmacy benefits manager, health plan, or covered entity  
46 pursuant to these established reporting requirements shall be considered proprietary and  
47 confidential and exempt from disclosure under the West Virginia Freedom of Information Act  
48 §29B-1-4(a)(1) of this code.

NOTE: The purpose of this bill is to provide that a pharmacy or pharmacist may decline to dispense a prescription drug or pharmacy service when reimbursement under West Virginia Public Employees Insurance is less than the pharmacy or pharmacist's acquisition cost for the same prescription drug or pharmacy service.

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