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 passage.]

AN ACT to amend and reenact §5-16-9 of the Code of West Virginia, 1931, as amended; to amend and reenact §33-51-2, §33-51-3, §33-51-8, and §33-51-9 of said code; and to amend said code by adding thereto two new sections, designated §33-51-11 and §33-51-12, all relating to the regulation of pharmacy benefit managers; updating the reporting requirements related Public Employees Insurance Agency; expanding scope; defining terms; regulating the reimbursements of pharmacy benefit managers; requiring a adequate network; providing rulemaking authority; providing an effective date; requiring filing of certain methodologies utilized by pharmacy benefit managers; prohibiting certain practices by pharmacy benefits managers; providing consumer choice for pharmacies; setting guidelines for pharmacy benefit plans; requiring rebates to be passed down; requiring reporting; and requiring the commissioner to consider information in reviewing 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.

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Severe food protein-induced enterocolitis syndrome;

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

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

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

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

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

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

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

(e) The provisions of §5A-3-1 *et seq.* of this code, relating to the Division of Purchasing of the Department of Finance and Administration, shall not apply to any contracts for any insurance coverage or professional services authorized to be executed under the provisions of this article. Before entering into any contract for any insurance coverage, as authorized in this article, the director shall invite competent bids from all qualified and licensed insurance companies or carriers, who may wish to offer plans for the insurance coverage desired: *Provided,* That the director shall negotiate and contract directly with healthcare providers and other entities,

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

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

(g) Each employee who is covered under any contract or contracts shall receive a statement of benefits to which the employee, his or her spouse and his or her dependents are entitled under the contract, setting forth the information as to whom the benefits are payable, to

whom claims shall be submitted and a summary of the provisions of the contract or contracts as they affect the employee, his or her spouse and his or her dependents.

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

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

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

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

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

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

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

(A) The cost of drug reimbursement;

(B) Dispensing fees;

(C) Copayments; and

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

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

(k) If the information required herein is not provided, the agency may terminate the contract with the pharmacy benefit manager and the Office of the Insurance Commissioner shall discipline 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.

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

§33-51-3. Definitions.

For purposes of this article:

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

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

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

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

"Claim level information" means data submitted by a pharmacy or required by a payer or claims processor to adjudicate a claim.

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

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

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

"Defined cost sharing" means a deductible payment or coinsurance amount imposed on an enrollee for a covered prescription drug under the enrollee's health plan.

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

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

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

"Insurance commissioner" or "commissioner" has the same meaning as defined in §33-1-5 of this code.

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

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

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

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

"Pharmacist" means an individual licensed by the West Virginia Board of Pharmacy to engage in the practice of pharmacy.

"Pharmacy" means any place within this state where drugs are dispensed and pharmacist care is provided.

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

"Pharmacy benefits management" means the performance of any of the following:

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

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

(3) The administration of pharmacy benefits, including:

(A) Operating a mail-service pharmacy;

(B) Claims processing;

(C) Managing a retail pharmacy network;

(D) Paying claims to a pharmacy for prescription drugs dispensed to covered individuals via retail or mail-order pharmacy;

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

(F) Rebate contracting administration; and

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

"Pharmacy benefits manager" means a person, business, or other entity that performs pharmacy benefits management for covered entities;

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

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

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

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

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

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

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

(a) A person or organization may not establish or operate as a pharmacy benefits manager in the state of West Virginia without first obtaining a license from the Insurance Commissioner pursuant to this section: *Provided*, That a pharmacy benefit manager registered pursuant to §33-5-7 of this code may continue to do business in the state until the Insurance Commissioner has completed the legislative rule as set forth in §33-55-10 of this code: *Provided, however*, That additionally the pharmacy benefit manager shall submit an application within six months of completion of the final rule. The Insurance Commissioner shall make an application form available on its publicly accessible internet website that includes a request for the following information:

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

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

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

(4) Any other information the Insurance Commissioner considers necessary and appropriate to establish the qualifications to receive a license as a pharmacy benefit manager to complete the licensure process, as set forth by legislative rule promulgated by the Insurance Commissioner pursuant to §33-51-10 of this code.

(b) Term and fee. —

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

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

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

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

(c) Licensure. —

(1) The Insurance Commissioner shall propose legislative rules, in accordance with §33-51-10 of this code, establishing the licensing, fees, application, financial standards, and reporting requirements of pharmacy benefit managers.

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

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

(d) Network adequacy. —

(1) A pharmacy benefit manager's network shall be reasonably adequate, shall provide for convenient patient access to pharmacies within a reasonable distance from a patient's residence and shall not be comprised only of mail-order benefits but must have a mix of mail-order benefits and physical stores in this state.

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

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

(e) Enforcement. —

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

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

(f) Applicability. —

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

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

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

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

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

(1) The total amount of the fee is identified, reported, and specifically explained for each line item on the remittance advice of the adjudicated claim; or

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

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

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

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

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

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

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

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

(2) A pharmacy benefits manager shall utilize the national average drug acquisition cost as a point of reference for the ingredient drug product component of a pharmacy's reimbursement for drugs appearing on the national average drug acquisition cost list; and,

(j) A pharmacy benefits manager may not:

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

(2) Engage in any practice that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) If a health benefit plan providing reimbursement to West Virginia residents for prescription drugs restricts pharmacy participation, the entity providing the health benefit plan shall notify, in writing, all pharmacies within the geographical coverage area of the health benefit plan, and offer to the pharmacies the opportunity to participate in the health benefit plan at least 60 days prior to the effective date of the plan. All pharmacies in the geographical coverage area of the plan shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. The entity providing the health benefit plan shall, through reasonable means, on a timely basis and on regular intervals, inform the beneficiaries of the plan of the names and locations of pharmacies that are participating in the plan as providers

of pharmacy services and prescription drugs. Additionally, participating pharmacies shall be entitled to announce their participation to their customers through a means acceptable to the pharmacy and the entity providing the health benefit plans. The pharmacy notification provisions of this section shall not apply when an individual or group is enrolled, but when the plan enters a particular county of the state.

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

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

(e) This section shall apply to all pharmacy benefits managers and health benefit plans providing pharmaceutical services benefits, including prescription drugs, to any resident of West Virginia. For purposes of this section, “health benefit plan” means any entity or program that provides reimbursement for pharmaceutical services. This section shall also apply to insurance companies and health maintenance organizations that provide or administer coverages and benefits for prescription drugs. This section shall not apply to any entity that has its own facility, employs or contracts with physicians, pharmacists, nurses and other health care personnel, and that dispenses prescription drugs from its own pharmacy to its employees and dependents enrolled in its health benefit plan; but this section shall apply to an entity otherwise excluded that contracts with an outside pharmacy or group of pharmacies to provide prescription drugs and services.

§33-51-12. Reporting requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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Chairman, House Committee

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Chairman, Senate Committee

Originating in the House.

In effect ninety days from passage.

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Clerk of the House of Delegates

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Clerk of the Senate

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Speaker of the House of Delegates

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President of the Senate

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The within ..... this the.....

day of ....., 2021.

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Governor