WEST VIRGINIA CODE: §33-51-12

§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.