WEST VIRGINIA CODE: §33-51-3

§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 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, required by a payor, or claims processor to adjudicate a claim.

“Covered individual” means a member, participant, enrollee, or beneficiary of a health benefit plan who is provided health care service coverage by a health benefit plan, 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 care payor to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

“Health care payor” or “payor” means a health insurance company, a health maintenance organization, a hospital, medical, or dental corporation, a health care corporation, an entity

that provides, administers, or manages a self-funded health benefit plan, including a governmental plan, or any other payor that provides prescription drug coverages, including a workers' compensation insurer. Health care payor does not include an insurer that provides coverage under a policy of casualty or property insurance.

"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 health benefit plan 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 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 health benefit plan 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 health benefit plans;

“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 payor 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 payors.

“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. The term “rebate” does not include any discount or payment that may be provided to or made to any 340B entity through such program.

"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.

"Specialty drug" means a drug used to treat chronic and complex, or rare medical conditions and requiring special handling or administration, provider care coordination, or patient education that cannot be provided by a non-specialty pharmacy or pharmacist.