WEST VIRGINIA CODE: §33-51-9

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

(d) With respect to a patient eligible to receive drugs subject to an agreement under 42 U.S.C. § 256b, a pharmacy benefit manager 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 this section, does not apply to 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 this subsection does apply to a Medicaid-managed care organization as described in 42 U.S.C. § 1396b(m). For purposes of this subsection, it shall be considered a discriminatory practice that prevents or interferes with a patient’s choice to receive drugs at a 340B entity if a pharmacy benefit manager places additional requirements, restrictions or unnecessary burdens upon a 340B entity that results in administrative costs or fees to the 340B entity that are not placed upon other pharmacies that do not participate in the 340B program, including affiliate

pharmacies of the pharmacy benefit manager or any other third-party, and further includes but is not limited to requiring a claim for a drug to include a modifier or be processed or resubmitted to indicate that the drug is a 340B drug: *Provided further*, That nothing in this subsection shall be construed to prohibit the Medicaid program or a Medicaid managed care organization as described in 42 U.S.C. § 1396b(m) from preventing duplicate discounts as described in 42 U.S.C. § 256b(a)(5)(A)(i). The provisions of this subsection are applicable to the West Virginia Public Employees Insurance Agency.

(e) 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.

(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 amount the pharmacy benefit manager reimburses itself or an affiliate for the same prescription drug or pharmacy service.

(g) 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.

(h)(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. The filed methodologies shall comply with the provisions of §33-51-9(e) of this code, and a pharmacy benefits manager shall not enter into a contract with a pharmacy that provides for reimbursement methodology not permissible under the provisions of §33-51-9(e) of this code.

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

(i) A pharmacy benefits manager may not:

(1) Discriminate in reimbursement, assess any fees or adjustments, or exclude a pharmacy

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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 processing deductibles or copayments as have been approved by a covered individual's health benefit plan.

(j) A pharmacy benefits manager may not charge a health care payor or health benefit plan an amount greater than the national average drug acquisition cost, if available, for prescription drugs. If the national average drug acquisition cost is not available, a pharmacy benefits manager may not charge a health care payor or health benefit plan an amount greater than the amount paid to the pharmacy: *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.

(k) 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 percent of all rebates received, or to be received, by the Pharmacy Benefit Manager, the GPO, or any other vendor 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: *Provided*, That for the Public Employee Insurance Agency, 100 percent of all rebates received, or to be received, by the Pharmacy Benefit Manager, the GPO, or any other vendor in connection with the dispensing or administration of the prescription drug shall be passed on to the plan to reduce premiums.

(l) A pharmacy benefit manager may not utilize, participate in or own any part of a group purchasing organization for purposes of avoiding the requirements of this article.

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