WEST VIRGINIA CODE CHAPTER 33 ARTICLE 51

§33-51-1. Short title.

This article may be cited and known as the Pharmacy Audit Integrity Act.

§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: (1) Has an investment or ownership interest in a pharmacy benefits manager licensed under this chapter; (2) Shares common ownership with a pharmacy benefits manager licensed under this chapter; or (3) 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 or 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 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.

"Group Purchasing Organization" or "GPO" is an entity that purchases, arranges for or negotiates the purchase of covered drugs, devices, biologicals, or medical supplies for a group of individuals or entities, but not solely for use by the entity itself.

"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 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.

"List Price" means the drug manufacturer's price for a drug to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, as reported in wholesale price guides or other publications of drug pricing data.

"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;

(G) Operating a rebate GPO; or

(H) 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.

"Rebate GPO" means a GPO that negotiates for rebates off of list price of prescription drugs for its participants. The term "Rebate GPO" does not include any such entity providing benefits to Medicaid, including but not limited to a state administered multi-state supplemental rebate pool.

"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.

§33-51-4. Procedures for conducting pharmacy audits.

(a) An entity conducting a pharmacy audit under this article shall conform to the following rules:

(1) Except as otherwise provided by federal or state law, an auditing entity conducting a pharmacy audit may have access to a pharmacy's previous audit report only if the report was prepared by that auditing entity.

(2) Information collected during a pharmacy audit is confidential by law, except that the auditing entity conducting the pharmacy audit may share the information with the pharmacy benefits manager and with the covered entity for which a pharmacy audit is being conducted and with any regulatory agencies and law-enforcement agencies as required by law.

(3) The auditing entity conducting a pharmacy audit may not compensate an employee or contractor with which an auditing entity contracts to conduct a pharmacy audit solely based on the amount claimed or the actual amount recouped by the pharmacy being audited.

(4) The auditing entity shall provide the pharmacy being audited with at least 14 calendar days" prior written notice before conducting a pharmacy audit unless both parties agree otherwise. If a delay of the audit is requested by the pharmacy, the pharmacy shall provide notice to the pharmacy benefits manager within 72 hours of receiving notice of the audit.

(5) The auditing entity may not initiate or schedule a pharmacy audit without the express consent of the pharmacy during the first five business days of any month for any pharmacy that averages in excess of 600 prescriptions filled per week.

(6) The auditing entity shall accept paper or electronic signature logs that document the delivery of prescription or nonproprietary drugs and pharmacist services to a health plan beneficiary or the beneficiary's caregiver or guardian.

(7) Prior to leaving the pharmacy after the on-site portion of the pharmacy audit, the auditing entity shall provide to the representative of the pharmacy a complete list of pharmacy records reviewed.

(8) A pharmacy audit that involves clinical judgment shall be conducted by, or in consultation with, a pharmacist.

(9) A pharmacy audit may not cover:

(A) A period of more than 24 months after the date a claim was submitted by the pharmacy to the pharmacy benefits manager or covered entity unless a longer period is required by law; or

(B) More than 250 prescriptions: Provided, That a refill does not constitute a separate

prescription for the purposes of this subparagraph.

(10) The auditing entity may not use extrapolation to calculate penalties or amounts to be charged back or recouped unless otherwise required by federal requirements or federal plans.

(11) The auditing entity may not include dispensing fees in the calculation of overpayments unless a prescription is considered a misfill. As used in this subdivision, "misfill" means a prescription that was not dispensed, a prescription error, a prescription where the prescriber denied the authorization request, or a prescription where an extra dispensing fee was charged.

(12) The auditing entity conducting a pharmacy audit or person acting on behalf of the auditing entity may not seek any fee, charge-back, recoupment, or other adjustment for a dispensed product, or any portion of a dispensed product, unless one of the following has occurred:

(A) Fraud or other intentional and willful misrepresentation as evidenced by a review of the claims data, statements, physical review, or other investigative methods;

(B) Dispensing in excess of the benefit design, as established by the plan sponsor;

(C) Prescriptions not filled in accordance with the prescriber’s order; or

(D) Actual overpayment to the pharmacy.

(13) Any fee, charge-back, recoupment, or other adjustment is limited to the actual financial harm associated with the dispensed product, or portion of the dispensed product, or the actual underpayment or overpayment as set forth in the criteria in subdivision (12) of this subsection.

(14) A pharmacy may do any of the following when a pharmacy audit is performed:

(A) A pharmacy may use authentic and verifiable statements or records, including, but not limited to, medication administration records of a nursing home, assisted living facility, hospital, or health care provider with prescriptive authority, to validate the pharmacy record and delivery; and

(B) A pharmacy may use any valid prescription, including, but not limited to, medication administration records, facsimiles, electronic prescriptions, electronically stored images of prescriptions, electronically created annotations, or documented telephone calls from the prescribing health care provider or practitioner’s agent, to validate claims in connection with prescriptions or changes in prescriptions or refills of prescription or nonproprietary drugs. Documentation of an oral prescription order that has been verified by the prescribing health care provider shall meet the provisions of this subparagraph for the initial audit review.

(b) An auditing entity shall provide the pharmacy with a written report of the pharmacy audit and comply with the following requirements:

(1) A preliminary pharmacy audit report shall be delivered to the pharmacy or its corporate parent within 60 calendar days after the completion of the pharmacy audit. The preliminary report shall include contact information for the auditing entity that conducted the pharmacy audit and an appropriate and accessible point of contact, including telephone number, facsimile number, e-mail address, and auditing firm name and address so that audit results, procedures and any discrepancies can be reviewed. The preliminary pharmacy audit report shall include, but not be limited to, claim level information for any discrepancy found and total dollar amounts of claims subject to recovery.

(2) A pharmacy is allowed at least 30 calendar days following receipt of the preliminary audit report to respond to the findings of the preliminary report.

(3) A final pharmacy audit report shall be delivered to the pharmacy or its corporate parent no later than 90 calendar days after completion of the pharmacy audit. The final pharmacy audit report shall include any response provided to the auditing entity by the pharmacy or corporate parent and shall consider and address such responses.

(4) The final audit report may be delivered electronically.

(5) A pharmacy may not be subject to a charge-back or recoupment for a clerical or recordkeeping error in a required document or record, including a typographical or computer error, unless the error resulted in overpayment to the pharmacy.

(6) An auditing entity conducting a pharmacy audit or person acting on behalf of the entity may not charge-back, recoup, or collect penalties from a pharmacy until the time to file an appeal of a final pharmacy audit report has passed or the appeals process has been exhausted, whichever is later.

(7) If an identified discrepancy in a pharmacy audit exceeds $25,000, future payments to the pharmacy in excess of that amount may be withheld pending adjudication of an appeal.

(8) No interest accrues for any party during the audit period, beginning with the notice of the pharmacy audit and ending with the conclusion of the appeals process.

(9) Except for Medicare claims, approval of drug, prescriber, or patient eligibility upon adjudication of a claim may not be reversed unless the pharmacy or pharmacist obtained adjudication by fraud or misrepresentation of claims elements.

§33-51-5. Appeals process.

A pharmacy may appeal a final audit report in accordance with the procedures established by the entity conducting the pharmacy audit.

§33-51-6. Limitations.

(a) The provisions of this article do not apply to an investigative audit of pharmacy records when:

(1) Fraud, waste, abuse or other intentional misconduct is indicated by physical review or review of claims data or statements; or

(2) Other investigative methods indicate a pharmacy is or has been engaged in criminal wrongdoing, fraud or other intentional or willful misrepresentation.

(b) This article does not supersede any audit requirements established by federal law.

§33-51-7. Pharmacy benefits manager and auditing entity registration.

(a) Prior to conducting business in the State of West Virginia, except as provided in subsection (d) of this section, an auditing entity shall register with the Insurance Commissioner. The 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; and

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

(b) Term and fee. —

(1) The term of registration 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. Such 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 its responsibilities under this article, but a single fee may not exceed $1,000.

(c) Registration. —

(1) The Insurance Commissioner shall issue a registration, as appropriate, to an applicant when the Insurance Commissioner determines that the applicant has submitted a completed application and paid the required registration fee.

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

(d) Duplicate registration. —

(1) A licensed insurer or other entity licensed by the commissioner pursuant to this chapter shall comply with the standards and procedures of this article but is not required to separately register as an auditing entity.

(2) A pharmacy benefits manager that is registered as a third-party administrator pursuant to §33-46-1 et seq. of this code shall comply with the standards and procedures of this article but is not required to register separately as an auditing entity.

§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 §33-51-7 of this code may continue to do business in the state until the Insurance Commissioner has completed the legislative rule as set forth in § §33-51-10 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. A pharmacy benefit manager's network report shall include a detailed description of any separate, sub-networks for specialty drugs.

(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.

(4) A pharmacy benefit manager may not require a pharmacy or pharmacist, as a condition for participating in the pharmacy benefit manager's network, to obtain or maintain accreditation, certification, or credentialing that is inconsistent with, more stringent than, or in addition to state requirements for licensure or other relevant federal or state standards.

(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.

§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 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.

§33-51-10. Commissioner required to propose rules.

The Insurance Commissioner shall propose rules for legislative approval in accordance with §29A-3-1 *et seq*. of this code that are necessary to effectuate the provisions of this article.

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

(a) A pharmacy benefits manager, 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 health benefit plan according to the terms offered by the health benefit plan;

(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 health benefit plan and agrees to the terms of reimbursement set forth by the insurer;

(3) Impose upon a pharmacy or pharmacist, as a condition of participation in a health benefit plan network, any course of study, accreditation, certification, or credentialing that is inconsistent with, more stringent than, or in addition to state requirements for licensure or certification as provided for in the §30-5-1 *et seq*. and legislative rules of the Board of Pharmacy.

(4) 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;

(5) 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;

(6) 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;

(7) Prohibit or otherwise limit a beneficiary's access to prescription drugs from a pharmacy or pharmacist enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage area by unreasonably designating the covered prescription drug as a specialty drug. Any beneficiary or pharmacy impacted by an alleged violation of this subsection may file a complaint with the Insurance Commissioner, who shall, in consultation with the West Virginia Board of Pharmacy, make a determination as to whether the covered prescription drug meets the definition of a specialty drug;

(8) Limit a beneficiary's access to specialty drugs;

(9) Require a beneficiary, as a condition of payment or reimbursement, to purchase

pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy; or

(10) 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 are 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 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. Participating pharmacies shall be entitled to 30 business days effective date notice for any subsequent contract amendment or provider manual change by a health benefit plan or a pharmacy benefit manager. 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 health benefit plan. 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. 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.

§33-51-13. Effective date.

Notwithstanding any other effective date to the contrary, the amendments to this article enacted during the 2022 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, 2023.

§33-51-14. Pharmacy dispensing fee study.

The Office of the Insurance Commissioner shall conduct a study of the cost to dispense outpatient prescription drugs in West Virginia by soliciting data and relevant information from licensed pharmacies and analyzing similar studies conducted in surrounding states within the previous two years.

The study shall be completed and submitted to the Legislative Oversight Commission on Health and Human Resources Accountability and the Joint Standing Committee on Insurance and PEIA by December 1, 2026, and biennially thereafter. The study and a final report shall be presented by the Office of the Insurance Commissioner to the Legislative Oversight Commission on Health and Human Resources Accountability and the Joint Standing Committee on Insurance and PEIA on or before January 15, 2027, and biennially thereafter.