

# WEST VIRGINIA LEGISLATURE

2022 REGULAR SESSION

**ENROLLED**

**Committee Substitute**

**for**

**House Bill 4112**

BY DELEGATES ROHRBACH, D. JEFFRIES, TULLY, PACK,

G. WARD, BATES, WORRELL, ROWAN, FORSHT, MALLOW,

AND JENNINGS

[Passed March 12, 2022; in effect ninety days from passage.]

FILED

2022 MAR 30 P 5:10

OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE

HB 4112

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1 AN ACT to amend and reenact §33-51-3, §33-51-8, §33-51-9, and §33-51-11 of the Code of  
2 West Virginia, 1931, as amended; and to amend said code by adding thereto a new  
3 section, designated §33-51-13, all relating to the regulation of pharmacy benefit  
4 managers; defining terms; updating terminology; prohibiting a pharmacy benefit manager  
5 from limiting a consumer's access to prescription drugs through the designation of  
6 specialty drugs; prohibiting a pharmacy benefit manager from placing certain requirements  
7 or restrictions on a pharmacist or pharmacy; updating requirements placed upon 340B  
8 entities; clarifying how drug acquisition cost is to be calculated; requiring pharmacy benefit  
9 managers to disclose any sub-networks for specialty drugs to the Insurance  
10 Commissioner; prohibiting a pharmacy benefit manager from limiting network access;  
11 providing clarification regarding assessment of fees related to adjudication of claims;  
12 providing clarification regarding criteria for requirements of methodologies; requiring  
13 notice of contract changes; and providing an effective date.

*Be it enacted by the Legislature of West Virginia:*

**ARTICLE 51. PHARMACY AUDIT INTEGRITY ACT.**

**§33-51-3. Definitions.**

1 For purposes of this article:  
2 "340B entity" means an entity participating in the federal 340B drug discount program, as  
3 described in 42 U.S.C. § 256b, including its pharmacy or pharmacies, or any pharmacy or  
4 pharmacies, contracted with the participating entity to dispense drugs purchased through such  
5 program.  
6 "Affiliate" means a pharmacy, pharmacist, or pharmacy technician which, either directly or  
7 indirectly through one or more intermediaries: (A) Has an investment or ownership interest in a  
8 pharmacy benefits manager licensed under this chapter; (B) shares common ownership with a  
9 pharmacy benefits manager licensed under this chapter; or (C) has an investor or ownership  
10 interest holder which is a pharmacy benefits manager licensed under this article.

11           “Auditing entity” means a person or company that performs a pharmacy audit, including a  
12 pharmacy benefits manager, managed care organization, or third-party administrator.

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

15           “Claim level information” means data submitted by a pharmacy, required by a payor, or  
16 claims processor to adjudicate a claim.

17           “Covered individual” means a member, participant, enrollee, or beneficiary of a health  
18 benefit plan who is provided health care service coverage by a health benefit plan, including a  
19 dependent or other person provided health coverage through the policy or contract of a covered  
20 individual.

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

25           “Defined cost sharing” means a deductible payment or coinsurance amount imposed on  
26 an enrollee for a covered prescription drug under the enrollee’s health plan.

27           “Health benefit plan” or “health plan” means a policy, contract, certificate, or agreement  
28 entered into, offered, or issued by a health care payor to provide, deliver, arrange for, pay for, or  
29 reimburse any of the costs of health care services.

30           “Health care payor” or “payor” means a health insurance company, a health maintenance  
31 organization, a hospital, medical, or dental corporation, a health care corporation, an entity that  
32 provides, administers, or manages a self-funded health benefit plan, including a governmental  
33 plan, or any other payor that provides prescription drug coverages, including a workers’  
34 compensation insurer. Health care payor does not include an insurer that provides coverage  
35 under a policy of casualty or property insurance.

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

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

40           “Insurance commissioner” or “commissioner” has the same meaning as defined in §33-1-  
41 5 of this code.

42           “Network” means a pharmacy or group of pharmacies that agree to provide prescription  
43 services to covered individuals on behalf of a health benefit plan in exchange for payment for its  
44 services by a pharmacy benefits manager or pharmacy services administration organization. The  
45 term includes a pharmacy that generally dispenses outpatient prescriptions to covered individuals  
46 or dispenses particular types of prescriptions, provides pharmacy services to particular types of  
47 covered individuals or dispenses prescriptions in particular health care settings, including  
48 networks of specialty, institutional or long-term care facilities.

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

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

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

58           “Pharmacist” means an individual licensed by the West Virginia Board of Pharmacy to  
59 engage in the practice of pharmacy.

60           “Pharmacy” means any place within this state where drugs are dispensed and pharmacist  
61 care is provided.

62           “Pharmacy audit” means an audit, conducted by or on behalf of an auditing entity of any  
63 records of a pharmacy for prescription or nonproprietary drugs dispensed by a pharmacy to a  
64 covered individual.

65           “Pharmacy benefits management” means the performance of any of the following:

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

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

70           (3) The administration of pharmacy benefits, including:

71           (A) Operating a mail-service pharmacy;

72           (B) Claims processing;

73           (C) Managing a retail pharmacy network;

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

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

78           (F) Rebate contracting administration; and

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

81           “Pharmacy benefits manager” means a person, business, or other entity that performs  
82 pharmacy benefits management for health benefit plans;

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

86           “Pharmacy services administration organization” means any entity that contracts with a  
87 pharmacy to assist with payor interactions and that may provide a variety of other administrative

88 services, including contracting with pharmacy benefits managers on behalf of pharmacies and  
89 managing pharmacies' claims payments from payors.

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

92 "Rebate" means any and all payments that accrue to a pharmacy benefits manager or its  
93 health plan client, directly or indirectly, from a pharmaceutical manufacturer, including, but not  
94 limited to, discounts, administration fees, credits, incentives, or penalties associated directly or  
95 indirectly in any way with claims administered on behalf of a health plan client. The term "rebate"  
96 does not include any discount or payment that may be provided to or made to any 340B entity  
97 through such program.

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

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

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

1 (a) A person or organization may not establish or operate as a pharmacy benefits manager  
2 in the state of West Virginia without first obtaining a license from the Insurance Commissioner  
3 pursuant to this section: *Provided*, That a pharmacy benefit manager registered pursuant to §33-  
4 51-7 of this code may continue to do business in the state until the Insurance Commissioner has  
5 completed the legislative rule as set forth in § 33-51-10 of this code: *Provided, however*, That  
6 additionally the pharmacy benefit manager shall submit an application within six months of  
7 completion of the final rule. The Insurance Commissioner shall make an application form available  
8 on its publicly accessible internet website that includes a request for the following information:

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

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

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

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

17 (b) *Term and fee.* —

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

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

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

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

28 (c) *Licensure.* —

29 (1) The Insurance Commissioner shall propose legislative rules, in accordance with §33-  
30 51-10 of this code, establishing the licensing, fees, application, financial standards, and reporting  
31 requirements of pharmacy benefit managers.

32 (2) Upon receipt of a completed application, evidence of financial responsibility, and fee,  
33 the Insurance Commissioner shall make a review of each applicant and shall issue a license if  
34 the applicant is qualified in accordance with the provisions of this section and the rules  
35 promulgated by the Insurance Commissioner pursuant to this section. The commissioner may



36 require additional information or submissions from an applicant and may obtain any documents  
37 or information reasonably necessary to verify the information contained in the application.

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

40 (d) *Network adequacy.* —

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

45 (2) A pharmacy benefit manager shall provide a pharmacy benefit manager's network  
46 report describing the pharmacy benefit manager's network and the mix of mail-order to physical  
47 stores in this state in a time and manner required by rule issued by the Insurance Commissioner  
48 pursuant to this section. A pharmacy benefit manager's network report shall include a detailed  
49 description of any separate, sub-networks for specialty drugs.

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

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

56 (e) *Enforcement.* —

57 (1) The Insurance Commissioner shall enforce this section and may examine or audit the  
58 books and records of a pharmacy benefit manager providing pharmacy benefits management to  
59 determine if the pharmacy benefit manager is in compliance with this section: *Provided*, That any  
60 information or data acquired during the examination or audit is considered proprietary and

61 confidential and exempt from disclosure under the West Virginia Freedom of Information Act  
62 pursuant to §29B-1-4(a)(1) of this code.

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

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

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

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

10 (c) A pharmacy benefit manager that reimburses a 340B entity for drugs that are subject  
11 to an agreement under 42 U.S.C. § 256b shall not reimburse the 340B entity for pharmacy-  
12 dispensed drugs at a rate lower than that paid for the same drug to pharmacies similar in  
13 prescription volume that are not 340B entities, and shall not assess any fee, charge-back, or other  
14 adjustment upon the 340B entity on the basis that the 340B entity participates in the program set  
15 forth in 42 U.S.C. §256b. For purposes of this subsection, the term "other adjustment" includes  
16 placing any additional requirements, restrictions, or unnecessary burdens upon the 340B entity  
17 that results in administrative costs or fees to the 340B entity that are not placed upon other  
18 pharmacies that do not participate in the 340B program, including affiliate pharmacies of the

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

25 (d) With respect to a patient eligible to receive drugs subject to an agreement under 42  
26 U.S.C. § 256b, a pharmacy benefit manager shall not discriminate against a 340B entity in a  
27 manner that prevents or interferes with the patient's choice to receive such drugs from the 340B  
28 entity: *Provided*, That this section, does not apply to the state Medicaid program when Medicaid  
29 is providing reimbursement for covered outpatient drugs, as that term is defined in 42 U.S.C.  
30 §1396r-8(k), on a fee-for-service basis: *Provided, however*, That this subsection does apply to a  
31 Medicaid-managed care organization as described in 42 U.S.C. § 1396b(m). For purposes of this  
32 subsection, it shall be considered a discriminatory practice that prevents or interferes with a  
33 patient's choice to receive drugs at a 340B entity if a pharmacy benefit manager places additional  
34 requirements, restrictions or unnecessary burdens upon a 340B entity that results in  
35 administrative costs or fees to the 340B entity that are not placed upon other pharmacies that do  
36 not participate in the 340B program, including affiliate pharmacies of the pharmacy benefit  
37 manager or any other third-party, and further includes but is not limited to requiring a claim for a  
38 drug to include a modifier or be processed or resubmitted to indicate that the drug is a 340B drug:  
39 *Provided further*, That nothing in this subsection shall be construed to prohibit the Medicaid  
40 program or a Medicaid managed care organization as described in 42 U.S.C. § 1396b(m) from  
41 preventing duplicate discounts as described in 42 U.S.C. 256b(a)(5)(A)(i). The provisions of this  
42 subsection are applicable to the West Virginia Public Employees Insurance Agency.

43 (e) A pharmacy benefit manager may not reimburse a pharmacy or pharmacist for a  
44 prescription drug or pharmacy service in an amount less than the national average drug

45 acquisition cost for the prescription drug or pharmacy service at the time the drug is administered  
46 or dispensed, plus a professional dispensing fee of \$10.49: *Provided*, That if the national average  
47 drug acquisition cost is not available at the time a drug is administered or dispensed, a pharmacy  
48 benefit manager may not reimburse in an amount that is less than the wholesale acquisition cost  
49 of the drug, as defined in 42 U.S.C. § 1395w-3a(c)(6)(B), plus a professional dispensing fee of  
50 \$10.49.

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

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

57 (h) (1) Any methodologies utilized by a pharmacy benefits manager in connection with  
58 reimbursement shall be filed with the commissioner at the time of initial licensure and at any time  
59 thereafter that the methodology is changed by the pharmacy benefit manager for use in  
60 determining maximum allowable cost appeals. The methodologies are not subject to disclosure  
61 and shall be treated as confidential and exempt from disclosure under the West Virginia Freedom  
62 of Information Act §29B-1-4(a)(1) of this code. The filed methodologies shall comply with the  
63 provisions of §33-51-9(e) of this code, and a pharmacy benefits manager shall not enter into a  
64 contract with a pharmacy that provides for reimbursement methodology not permissible under the  
65 provisions of §33-51-9(e) of this code.

66 (2) For purposes of complying with the provisions of §33-51-9(e) of this code, a pharmacy  
67 benefits manager shall utilize the most recently published monthly national average drug  
68 acquisition cost as a point of reference for the ingredient drug product component of a pharmacy's  
69 reimbursement for drugs appearing on the national average drug acquisition cost list; and,

70 (i) A pharmacy benefits manager may not:

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

74 (2) Engage in any practice that:

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

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

80 (C) Derives any revenue from a pharmacy or insured in connection with performing  
81 pharmacy benefits management services: *Provided*, That this may not be construed to prohibit  
82 pharmacy benefits managers from processing deductibles or copayments as have been approved  
83 by a covered individual's health benefit plan.

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

89 (k) A covered individual's defined cost sharing for each prescription drug shall be  
90 calculated at the point of sale based on a price that is reduced by an amount equal to at least 100  
91 percent of all rebates received, or to be received, in connection with the dispensing or  
92 administration of the prescription drug. Any rebate over and above the defined cost sharing would  
93 then be passed on to the health plan to reduce premiums. Nothing precludes an insurer from  
94 decreasing a covered individual's defined cost sharing by an amount greater than what is  
95 previously stated. The commissioner may propose a legislative rule or by policy effectuate the  
96 provisions of this subsection.

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

1 (a) A pharmacy benefits manager, may not:

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

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

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

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

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

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

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

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

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

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

42 (b) If a health benefit plan providing reimbursement to West Virginia residents for  
43 prescription drugs restricts pharmacy participation, the health benefit plan shall notify, in writing,  
44 all pharmacies within the geographical coverage area of the health benefit plan, and offer to the  
45 pharmacies the opportunity to participate in the health benefit plan at least 60 days prior to the  
46 effective date of the plan. All pharmacies in the geographical coverage area of the plan shall be  
47 eligible to participate under identical reimbursement terms for providing pharmacy services,  
48 including prescription drugs. Participating pharmacies shall be entitled to 30 business days  
49 effective date notice for any subsequent contract amendment or provider manual change by a  
50 health benefit plan or a pharmacy benefit manager. The health benefit plan shall, through  
51 reasonable means, on a timely basis and on regular intervals, inform the beneficiaries of the plan

52 of the names and locations of pharmacies that are participating in the plan as providers of  
53 pharmacy services and prescription drugs. Additionally, participating pharmacies shall be entitled  
54 to announce their participation to their customers through a means acceptable to the pharmacy  
55 and the health benefit plan. The pharmacy notification provisions of this section shall not apply  
56 when an individual or group is enrolled, but when the plan enters a particular county of the state.

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

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

61 (e) This section shall apply to all pharmacy benefits managers and health benefit plans  
62 providing pharmaceutical services benefits, including prescription drugs, to any resident of West  
63 Virginia. This section shall not apply to any entity that has its own facility, employs or contracts  
64 with physicians, pharmacists, nurses, and other health care personnel, and that dispenses  
65 prescription drugs from its own pharmacy to its employees and dependents enrolled in its health  
66 benefit plan; but this section shall apply to an entity otherwise excluded that contracts with an  
67 outside pharmacy or group of pharmacies to provide prescription drugs and services.

**§33-51-13. Effective date.**

1 Notwithstanding any other effective date to the contrary, the amendments to this article  
2 enacted during the 2022 regular legislative session shall apply to all policies, contracts, plans, or  
3 agreements subject to this section that are delivered, executed, amended, adjusted, or renewed  
4 on or after January 1, 2023.



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

  
.....  
Chairman, House Committee

  
.....  
Chairman, Senate Committee

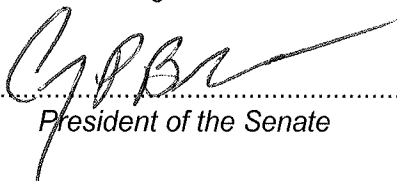
Originating in the House.

In effect ninety days from passage.

  
.....  
Clerk of the House of Delegates

  
.....  
Clerk of the Senate

  
.....  
Speaker of the House of Delegates

  
.....  
President of the Senate

2022 MAR 30 P 5:10  
OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE

FILED

The within is approved this the 30th  
day of March ..... 2022

  
.....  
Governor

PRESENTED TO THE GOVERNOR

MAR 25 2022

Time 11:38 am