WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

Introduced

Senate Bill 907

FISCAL NOTE

By Senator Helton

[Introduced February 10, 2026; referred

to the Committee on Health and Human Resources;

and then to the Committee of Finance]

A BILL to amend and reenact §5-16-9 and §33-51-9 of the Code of West Virginia, 1931, as amended; and to amend the code by adding two new sections, designated §9-5-34 and §33-51-14, relating to pharmacy benefit managers and state pharmacy purchasing; requiring an annual dispensing fee study; limiting amounts charged by pharmacy benefit managers; prohibiting certain pharmacy benefit manager contracts with West Virginia Medicaid and the West Virginia Public Employees Insurance Agency; and requiring implementation of a pharmacy cost containment tool.

Be it enacted by the Legislature of West Virginia:

CHAPTER 33. INSURANCE.

ARTICLE 51. PHARMACY AUDIT INTEGRITY ACT.

§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; and,

(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 shall offer a health plan the option of charging such health plan the same price for a prescription drug as it pays a pharmacy for the prescription drug.~~ 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, 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.

(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.

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

The Office of the Insurance Commissioner shall conduct an annual 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 annual 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 31, 2026, and annually 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 annually thereafter.

CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE GOVERNOR, SECRETARY OF STATE AND ATTORNEY GENERAL; BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES, COMMISSIONS, OFFICES, PROGRAMS, ETC.

ARTICLE 16. PUBLIC EMPLOYEES INSURANCE AGENCY

§5-16-9. Authorization to execute contracts.

(a) The director is given exclusive authorization to execute such contract or contracts as are necessary to carry out the provisions of this article.

(b) The provisions of §5A-3-1 *et seq*. of this code, relating to the Division of Purchasing of the Department of Finance and Administration, shall not apply to any contracts for any insurance coverage or professional services authorized to be executed under the provisions of this article. Before entering into any contract for any insurance coverage, as authorized in this article, the director shall invite competent bids from all qualified and licensed insurance companies or carriers that may wish to offer plans for the insurance coverage desired. The director shall negotiate and contract directly with health care providers and other entities, organizations, and vendors in order to secure competitive premiums, prices, and other financial advantages. The director shall deal directly with insurers or health care providers and other entities, organizations, and vendors in presenting specifications and receiving quotations for bid purposes. No commission or finder's fee, or any combination thereof, shall be paid to any individual or agent: *Provided*, That this shall not preclude an underwriting insurance company or companies, at their own expense, from appointing a licensed resident agent within this state to service the companies' contracts awarded under the provisions of this article. Commissions reasonably related to actual service rendered for the agent or agents may be paid by the underwriting company or companies. In no event shall payment be made to any agent or agents when no actual services are rendered or performed. The director shall award the contract or contracts on a competitive basis. In awarding the contract or contracts, the director shall consider the experience of the offering agency, corporation, insurance company, or service organization in the group hospital and surgical insurance field, group major medical insurance field, group prescription drug field, and group life and accidental death insurance field, and its facilities for the handling of claims. In evaluating these factors, the director may employ the services of impartial, professional insurance analysts or actuaries, or both. Any

contract executed by the director with a selected carrier shall be a contract to govern all eligible employees subject to the provisions of this article. Nothing contained in this article shall prohibit any insurance carrier from soliciting employees covered hereunder to purchase additional hospital and surgical, major medical, or life and accidental death insurance coverage.

(c) The director may authorize the carrier with whom a primary contract is executed to reinsure portions of the contract with other carriers which elect to be a reinsurer and who are legally qualified to enter into a reinsurance agreement under the laws of this state.

(d) Each employee who is covered under any contract or contracts shall receive a statement of benefits to which the employee, his or her spouse, and his or her dependents are entitled under the contract, setting forth the information as to whom the benefits are payable, to whom claims shall be submitted, and a summary of the provisions of the contract or contracts as they affect the employee, his or her spouse, and his or her dependents.

(e) The director may at the end of any contract period discontinue any contract or contracts it has executed with any carrier and replace the same with a contract or contracts with any other carrier or carriers meeting the requirements of this article.

(f) The director shall include language in all contracts for pharmacy benefits management, as defined by §33-51-3 of this code, requiring the pharmacy benefit manager to report quarterly to the agency the following:

(1) The overall total amount charged to the agency for all claims processed by the pharmacy benefit manager during the quarter;

(2) The overall total amount of reimbursements paid to pharmacy providers during the quarter;

(3) The overall total number of claims in which the pharmacy benefits manager reimbursed a pharmacy provider for less than the amount charged to the agency for all claims processed by the pharmacy benefit manager during the quarter; and

(4) For all pharmacy claims, the total amount paid to the pharmacy provider per claim,

including, but not limited to, the following:

(A) The cost of drug reimbursement;

(B) Dispensing fees;

(C) Copayments;

(D) The amount charged to the agency for each claim by the pharmacy benefit manager;

(E) Date of service;

(F) NDC-11;

(G) Drug name;

(H) Drug strength;

(I) Quantity;

(J) Days of therapy;

(K) Rx count;

(L) Mail/retail code;

(M) Brand/generic indicator;

(N) Specialty drug indicator;

(O) Compound indicator;

(P) Formulary indicator;

(Q) Gross cost;

(R) Member cost;

(S) Plan cost;

(T) Dispense as written;

(U) Pharmacy NPI number;

(V) Pharmacy Claim ID;

(W) Prescriber NPI number;

(X) Pharmacy name; and

(Y) Ingredient cost.

In the event there is a difference between the amount for any pharmacy claim paid to the pharmacy provider and the amount reimbursed to the agency, the pharmacy benefit manager shall report an itemization of all administrative fees, rebates, or processing charges associated with the claim. The director shall provide an annual report to the Joint Committee on Health detailing the information required by this section, including any difference or spread between the overall amount paid by pharmacy benefit managers to the pharmacy providers and the overall amount charged to the agency for each claim by the pharmacy benefit manager. To the extent necessary, the director shall use aggregated, nonproprietary data only: *Provided*, That the director must provide a clear and concise summary of the total amounts charged to the agency and reimbursed to pharmacy providers on an annual basis.

(g) If the information required herein is not provided, the agency may terminate the contract with the pharmacy benefit manager and the Office of the Insurance Commissioner shall discipline the pharmacy benefit manager as provided in §33-51-8(e) of this code.

(h) The Public Employees Insurance Agency shall contract with networks to provide care to its members out of state.

(i) The Public Employees Insurance Agency shall require each of the following in its requests for proposals and contracts with a pharmacy benefit manager:

(1) The pharmacy benefit manager shall disclose all information and data related to contracting, reimbursement, networks, rebates, fees, and any other information and data requested by the Public Employees Insurance Agency, the Legislature, and vendors for the purpose of performing study and analysis. ~~Effective with the changes made to this section during the regular session of the Legislature, 2024, a comprehensive pharmacy business intelligence study and analysis shall be conducted by an organization with expertise in studying and analyzing pharmacy benefit managers to determine what, if any, changes could be made to facilitate savings with respect to the Public Employees Insurance Agency's pharmacy benefit manager services. A final report, including recommendations, shall be presented no later than December 31, 2024, to~~

~~the Public Employees Insurance Agency and the Joint Committee on Government and Finance.~~

(2) A pharmacy benefit manager shall not reimburse a West Virginia pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the national average drug acquisition cost for a prescription drug or pharmacy service at the time the drug is administered or dispensed, plus a professional dispensing fee at least equal to the professional dispensing fee paid by West Virginia Medicaid for outpatient drugs. Increases to the professional dispensing fee may be set by the Director in accordance with this subdivision: *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 a West Virginia pharmacy or pharmacist 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 dispensing fee as described in this subdivision. A West Virginia pharmacy is a domestic business entity as registered with the West Virginia Secretary of State. The provisions in this subdivision shall be effective for the Public Employees Insurance Agency plan year beginning on July 1, 2024.

(j) The Public Employees Insurance Agency may not contract for pharmacy benefits management services with a pharmacy benefit manager if the pharmacy benefit manager owns pharmacies licensed in West Virginia or has affiliate pharmacies licensed in West Virginia, as "affiliate" is defined in §33-51-3 of this code.

(k) The Public Employees Insurance Agency may not contract for pharmacy benefits management services with a pharmacy benefit manager without the Public Employees Insurance Agency and the pharmacy benefits manager being subject to the requirements of §33-51-1, *et seq.* of this code and the jurisdiction of the Office of the Insurance Commissioner.

(k) By July 1, 2026, the Public Employees Insurance Agency shall contract with and implement a pharmacy cost containment tool that actively engages prescribing providers by presenting information related to lowest net cost pharmaceutical decisions and related to reductions to polypharmacy rates, if clinically reviewed and appropriate.

(1) The vendor managing this service shall be separate and distinct from any pharmacy benefit management contract that any state agency may have in the management of the pharmacy benefit.

(2) The vendor shall work with the Public Employees Insurance Agency to ensure that the net lowest cost outcome is achieved, including calculation of drug manufacturer rebates and other considerations that may be offered to the state.

(3) Prescribing providers engaged by the vendor are not required to modify their prescribing based on the information presented pursuant to this subsection.

(4) The pharmacy cost containment tool contract shall contain provisions guaranteeing the state an itemized monthly activity and savings report and a total net savings guarantee related to all expenditures and fees for the pharmacy cost containment service.

CHAPTER 9. HUMAN SERVICES.

ARTICLE 5. MISCELLANEOUS PROVISIONS.

§9-5-34. Medicaid pharmacy benefit management; prohibited contracting; pharmacy cost containment tool.

(a) For purposes of this section, "pharmacy benefit manager" and "affiliate" have the meanings ascribed to those terms in §33-51-3 of this code.

(b) To the extent that Medicaid has a pharmacy benefit manager managing its pharmacy contract, the Department of Human Services, including the Bureau for Medical Services, may not contract for pharmacy benefits management services for the Medicaid program with a pharmacy benefit manager if the pharmacy benefit manager owns pharmacies licensed in West Virginia or has affiliate pharmacies licensed in West Virginia.

(c) By July 1, 2026, the Medicaid program shall contract with and implement a pharmacy cost containment tool that actively engages prescribing providers by presenting information related to lowest net cost pharmaceutical decisions and related to reductions to polypharmacy

rates, if clinically reviewed and appropriate.

(1) The vendor managing this service shall be separate and distinct from any pharmacy benefit management contract that any state agency may have in the management of the pharmacy benefit.

(2) The vendor shall work with the state agency to ensure that the net lowest cost outcome is achieved, including calculation of drug manufacturer rebates and other considerations that may be offered to the state.

(3) Prescribing providers engaged by the vendor are not required to modify their prescribing based on the information presented pursuant to this subsection.

(4) The pharmacy cost containment tool contract shall contain provisions guaranteeing the state an itemized monthly activity and savings report and a total net savings guarantee related to all expenditures and fees for the pharmacy cost containment service.

NOTE: The purpose of this bill is to is to regulate pharmacy benefit managers and state pharmacy purchasing by requiring an annual pharmacy dispensing fee study, limiting amounts charged by pharmacy benefit managers, prohibiting certain pharmacy benefit manager contracts with West Virginia Medicaid and the West Virginia Public Employees Insurance Agency, and requiring implementation of a pharmacy cost containment tool.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.