



## WEST VIRGINIA INSURANCE BULLETIN

### No. 22-04

*Insurance Bulletins are issued when the Commissioner renders formal opinions, guidance or expectations on matters or issues, explains how new statutes or rules will be implemented or applied, or advises of interpretation or application of existing statutes or rules.*

### ► Freedom of Consumer Choice for Pharmacy ◀

During the 2021 Legislative Session, the West Virginia Legislature passed House Bill 2263, which amended West Virginia's Pharmacy Benefit Manager (PBM) regulation and licensure laws, located generally in Chapter 33, Article 51 of the West Virginia Code. House Bill 2263 (2021) passed the Legislature unanimously and was signed by Governor Jim Justice on April 9, 2021. Some of the substantive updates to West Virginia's PBM law concern PBM pharmacy networks and "freedom of consumer choice" (FOC) regarding pharmacy benefits. The West Virginia Offices of the Insurance Commissioner (OIC) is issuing this Insurance Bulletin to provide guidance and educate stakeholders regarding the new PBM law, specifically relating to pharmacy networks and FOC for pharmacy benefits.

Pursuant to W.Va. Code §33-51-11(a), a health benefit plan or PBM may not:

- Prohibit or limit any covered individual from selecting a pharmacy or pharmacist of his or her choice who has agreed to participate in the plan according to the terms offered by the insurer;
- 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 insurer under the policy or plan and agrees to the terms of reimbursement set forth by the insurer;
- 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;
- Impose a monetary advantage or penalty (which includes a higher copayment, a reduction in reimbursement for services, or promotion of one participating pharmacy over another by these methods) 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;

- 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;
- Require a beneficiary, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy; or
- 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 is 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.

W.Va. Code §33-51-11 applies to “all pharmacy benefits managers and health benefit plans providing pharmaceutical services benefits, including prescription drugs, to any resident of West Virginia.” For purposes of W.Va. Code §33-51-11, “health benefit plan” means any entity or program that provides reimbursement for pharmaceutical services. W.Va. Code §33-51-11 also applies to insurance companies and health maintenance organizations that provide or administer coverages and benefits for prescription drugs. W.Va. Code §33-51-11 does 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 does apply to an entity otherwise excluded that contracts with an outside pharmacy or group of pharmacies to provide prescription drugs and services. *See* W.Va. Code §33-51-11(e).

Additionally, W.Va. Code §33-51-8(d) provides:

(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.

(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.

Essentially, a PBM must have an adequate and reasonable network that is conveniently accessible for consumers. The network must have physical stores and mail-order options. A PBM must allow a pharmacy or pharmacist to participate in its network as a contract provider so long as the pharmacy or pharmacist agrees to the terms and requirements set forth by the insurer, including terms of reimbursement, which are specifically set forth in W.Va. Code §33-51-9(f) and which must be consistent among all pharmacies that participate. A pharmacy or pharmacist does not automatically become a member of a PBM’s network due to

the passage or implementation of the amended PBM law. A pharmacy or pharmacist must apply or seek to become a contract provider with the PBM so the pharmacy or pharmacist can agree to the terms and requirements, including reimbursement. However, W.Va. Code §33-51-11(b) provides that “[i]f a health benefit plan providing reimbursement to West Virginia residents for prescription drugs restricts pharmacy participation, the entity providing 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. The entity providing 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 entity providing the health benefit plans.” The notification provision does not apply when an individual or group is enrolled, but is applicable when the plan enters a particular county of the state. *See* §33-51-11(b).

A PBM may not require a beneficiary to purchase pharmacy services, including prescription drugs, exclusively through a mail-order service. W.Va. Code §§33-16-3q, 33-24-7h, 33-25-8f, 33-25A-8g, all enacted in 2003, generally provide that an insurer issuing a group accident and sickness policy, a Hospital, Medical, Dental or Health Service Corporation, a Health Care Corporation, or a Health Maintenance Organization (“HMO”) may not require any covered person to obtain prescription drugs from a mail-order pharmacy in order to obtain prescription drug benefits, and may not violate this prohibition by using an agent, contractor or administrator that requires the covered person to obtain prescription drugs from a mail-order pharmacy. Historically, some PBMs have required use of mail order pharmacies for specialty drugs, as well as for ongoing maintenance medications. This practice is prohibited. Consumers must be able to fill their drug prescriptions at any pharmacy of their choice, so long as that pharmacy participates in the plan as a contract provider by agreeing to the terms and requirements of the insurer. Critically, a PBM or health plan may not deny a pharmacy the right to participate as a contract provider in the PBM’s network if the pharmacy seeks to participate as a contract provider in the PBM’s network and agrees to provide pharmacy services, including prescription drugs, that meet the terms and requirements set forth by the insurer and agrees to the terms and requirements.

The OIC recognizes the unique need for specialty pharmacies and the important role that they play in the healthcare delivery system. Any specialty pharmacy, whether a mail-order or a physical retail store, must have the skill, capability and personnel to provide the patient education and clinical support required, in addition to providing the unique storage and shipping requirements that the specialty drugs may require. However, pursuant to W.Va. Code §§33-51-8(d) and 33-51-11, patients must have a choice to procure prescription drugs in either manner. Neither W.Va. Code §33-51-8(d) nor W.Va. Code §33-51-11 afford a “carve-out” or exception for specialty drugs under which a PBM or health benefit plan can deprive a covered individual of this choice. As such, a PBM cannot deny a specialty pharmacy that is a physical retail store the right to participate in its network as a contract provider, so long as the specialty pharmacy meets and agrees to the applicable terms and requirements of the insurer.

The OIC has consistently received questions regarding whether the FOC for pharmacy provisions apply to PBMs that provide services under a plan that is subject to the Employee Retirement Income Security Act of 1974 (ERISA) or is pre-empted by ERISA. W.Va. Code §33-51-11(e) provides that the FOC pharmacy provisions shall apply to all PBMs and health benefit plans providing pharmaceutical services benefits, including prescription drugs, to any resident of West Virginia. The Legislature further clarified that, for purposes of this code section, “health benefit plan” means any entity or program that provides reimbursement for pharmaceutical services. As such, it appears that the legislative intent was for it to apply to all PBMs

regardless of whether the PBM was providing services for a fully insured plan or ERISA plan. Previously, W.Va. Code §§33-51-8 and 33-51-9, regarding licensure and regulation of PBMs, contained expressed exemptions for PBMs that provided coverage of prescription drugs under an ERISA plan. The ERISA exemptions were expressly removed from W.Va. Code §§33-51-8 and 33-51-9 in House Bill 2263 by the West Virginia Legislature in 2021, after the United States Supreme Court's decision in *Rutledge v. Pharmaceutical Care Management Assn.*, 141 S. Ct. 474 (2020). Additionally, the Legislature chose not to include an ERISA exemption in W.Va. Code §33-51-11. Therefore, the FOC law is not referring to nor related to ERISA or subject to its preemptions. Upon review, the FOC law does not have an impermissible reference to ERISA plans nor does it act immediately and exclusively upon ERISA plans. The existence of an ERISA plan is not essential to the law's operation. Therefore, the FOC law is not preempted by ERISA. ERISA is "primarily concerned with preempting laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits." *Id.* West Virginia's FOC law does not require payment of any specific benefit. Conversely, the law requires a pharmacy to agree to provide pharmacy services, including, but not limited to, prescription drugs, that meet the terms and requirements set forth by the insurer under the policy or plan and agrees to the terms of reimbursement set forth by the insurer. The FOC law does not impermissibly require any changes to the structure of benefits as the pharmacy by statute must agree to the PBMs terms in order to join the network.

Finally, W.Va. Code §33-51-11(c) prohibits the OIC from approving the licensure of any PBM or approving any health benefit plan that does not conform to the FOC law for pharmacy provisions. W.Va. Code §33-51-11(d) gives covered individuals and pharmacies a direct legal cause of action for injunction against PBMs and health benefit plans that do not comply. The OIC will not approve health benefit plans that are filed with this agency if they restrict drugs to mail-order pharmacies only in violation of W.Va. Code §§33-16-3q, 33-24-7h, 33-25-8f, or 33-25A-8g, or refuse to allow pharmacies or pharmacists to join their networks as contract providers pursuant to W.Va. Code §33-51-11. Additionally, A PBM may be subject to licensure suspension, revocation, audit or examination and/or monetary penalties for violations of Chapter 33, Article 51 of the West Virginia Code. *See* W.Va. Code St. Rules §114-99-1 *et seq.* A PBM facing regulatory enforcement action may seek a hearing before the OIC pursuant to W.Va. Code §33-2-13.

You may contact the OIC's Consumer Services Division at 1-888-TRY-WVIC (1-888-879-9842) or [OICConsumerServices@wv.gov](mailto:OICConsumerServices@wv.gov) for assistance or to file a complaint regarding PBM reimbursement. You may also contact the OIC's Legal Division at [OICLegal@wv.gov](mailto:OICLegal@wv.gov) or Health Policy Division at [OICHealthPolicy@wv.gov](mailto:OICHealthPolicy@wv.gov).

Please e-mail any questions concerning this Insurance Bulletin to [OICBulletins@wv.gov](mailto:OICBulletins@wv.gov).

**Issued: January 11, 2022**



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