

1 SENATE BILL NO. 669

2 AMENDMENT IN THE NATURE OF A SUBSTITUTE

3 (Proposed by the Senate Committee on Commerce and Labor

4 on _____)

5 (Patron Prior to Substitute—Senator Rouse)

6 *A BILL to amend and reenact §§ 38.2-3465, 38.2-3467, 38.2-3468, and 38.2-3470 of the Code of Virginia,*
7 *relating to pharmacy benefits managers; requirements; application of law; report.*8 **Be it enacted by the General Assembly of Virginia:**9 **1. That §§ 38.2-3465, 38.2-3467, 38.2-3468, and 38.2-3470 of the Code of Virginia are amended and**
10 **reenacted as follows:**11 **§ 38.2-3465. Definitions.**

12 A. As used in this article, unless the context requires a different meaning:

13 "Aggregate retained rebate percentage" means the sum total dollar amount of a pharmacy benefits
14 manager's retained rebates relating to all carrier clients of such pharmacy benefits manager divided by the
15 sum total dollar amount of all rebates received by such pharmacy benefits manager relating to all such clients.16 "Carrier" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15. However, "carrier"
17 does not include a nonprofit health maintenance organization that operates as a group model whose internal
18 pharmacy operation exclusively serves the members or patients of the nonprofit health maintenance
19 organization.20 "Claim" means a request from a pharmacy or pharmacist to be reimbursed for the cost of administering,
21 filling, or refilling a prescription for a drug or for providing a medical supply or device.22 "Claims processing services" means the administrative services performed in connection with the
23 processing and adjudicating of claims relating to pharmacist services that include (i) receiving payments for
24 pharmacist services, (ii) making payments to pharmacists or pharmacies for pharmacist services, or (iii) both
25 receiving and making payments.26 "Contract pharmacy" means a pharmacy operating under contract with a 340B-covered entity to provide
27 dispensing services to the 340B-covered entity, as described in 75 Fed. Reg. 10272 (March 5, 2010) or any
28 superseding guidance published thereafter.29 "Covered entity" means an entity described in § 340B(a)(4) of the federal Public Health Service Act, 42
30 U.S.C. § 256B(a)(4).

31 "Covered individual" means an individual receiving prescription medication coverage or reimbursement
32 provided by a pharmacy benefits manager or a carrier under a health benefit plan.

33 "Health benefit plan" has the same meaning ascribed thereto in § 38.2-3438.

34 "Mail order pharmacy" means a pharmacy whose primary business is to receive prescriptions by mail or
35 through electronic submissions and to dispense medication to covered individuals through the use of the
36 United States mail or other common or contract carrier services and that provides any consultation with
37 covered individuals electronically rather than face-to-face.

38 *"Pass-through pricing model" means a payment model used by a pharmacy benefits manager in which the
39 payments made by the carrier or health benefit plan to the pharmacy benefits manager for covered outpatient
40 drugs are:*

41 *1. Equivalent to the payments the pharmacy benefits manager makes to a pharmacist or pharmacy for
42 such drugs, including any contracted professional dispensing fee between the pharmacy benefits manager
43 and its network of pharmacies. That dispensing fee would be paid if the health care service plan or health
44 insurer was making the payments directly; and*

45 *2. Passed through in their entirety by the carrier or health benefit plan or by the pharmacy benefits
46 manager to the pharmacist or pharmacy that dispenses the drugs, and the payments are made in a manner
47 that is not offset by reconciliation.*

48 "Pharmacy benefits management" means the administration or management of prescription drug benefits
49 provided by a carrier for the benefit of covered individuals. "Pharmacy benefits management" does not
50 include any service provided by a nonprofit health maintenance organization that operates as a group model
51 provided that the service is furnished through the internal pharmacy operation exclusively serves the
52 members or patients of the nonprofit health maintenance organization.

53 "Pharmacy benefits manager" or "PBM" means an entity that performs pharmacy benefits management.
54 "Pharmacy benefits manager" includes an entity acting for a PBM in a contractual relationship in the
55 performance of pharmacy benefits management for a carrier, nonprofit hospital, or third-party payor under a
56 health program administered by the Commonwealth.

57 "Pharmacy benefits manager affiliate" means a business, pharmacy, or pharmacist that directly or
58 indirectly, through one or more intermediaries, owns or controls, is owned or controlled by, or is under
59 common ownership interest or control with a pharmacy benefits manager.

60 "Rebate" means a discount or other price concession, including without limitation incentives,

61 disbursements, and reasonable estimates of a volume-based discount, or a payment that is (i) based on
62 utilization of a prescription drug and (ii) paid by a manufacturer or third party, directly or indirectly, to a
63 pharmacy benefits manager, pharmacy services administrative organization, or pharmacy after a claim has
64 been processed and paid at a pharmacy.

65 "Retail community pharmacy" means a pharmacy that is open to the public, serves walk-in customers, and
66 makes available face-to-face consultations between licensed pharmacists and persons to whom medications
67 are dispensed.

68 "Retained rebate" means a rebate that is not passed on to a health benefit plan.

69 "Retained rebate percentage" means the sum total dollar amount of a pharmacy benefits manager's
70 retained rebates relating to a health benefit plan divided by the sum total dollar amount of all rebates received
71 by such pharmacy benefits manager relating to such health benefit plan.

72 "Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits manager
73 charges a health benefit plan a contracted price for prescription drugs, and the contracted price for the
74 prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the
75 pharmacist or pharmacy for pharmacist services.

76 **§ 38.2-3467. Prohibited conduct by carriers and pharmacy benefits managers.**

77 A. No carrier on its own or through its contracted pharmacy benefits manager or representative of a
78 pharmacy benefits manager shall:

79 1. Cause or knowingly permit the use of any advertisement, promotion, solicitation, representation,
80 proposal, or offer that is untrue;

81 2. Charge a pharmacist or pharmacy a fee *(i)* related to the adjudication of a claim other than a reasonable
82 fee for an initial claim submission *or (ii) to process a claim electronically*;

83 3. Reimburse a pharmacy or pharmacist an amount less than the amount that the pharmacy benefits
84 manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services,
85 calculated on a per-unit basis using the same generic product identifier or generic code number and reflecting
86 all drug manufacturer's rebates, direct and indirect administrative fees, and costs and any remuneration;

87 4. Penalize or retaliate against a pharmacist or pharmacy for exercising rights provided pursuant to the
88 provisions of this article, *including penalizing or retaliating by (i) terminating or refusing to renew a contract*
89 *with the pharmacist or pharmacy, (ii) subjecting the pharmacist or pharmacy to increased audits without*

90 cause, or (iii) failing to promptly pay the pharmacist or pharmacy money owed to such pharmacist or
91 pharmacy;

92 5. Impose requirements, exclusions, reimbursement terms, or other conditions on a covered entity or
93 contract pharmacy that differ from those applied to entities or pharmacies that are not covered entities or
94 contract pharmacies on the basis that the entity or pharmacy is a covered entity or contract pharmacy or that
95 the entity or pharmacy dispenses 340B-covered drugs. Nothing in this subdivision shall (i) apply to drugs
96 with an annual estimated per-patient cost exceeding \$250,000 or (ii) prohibit the identification of a 340B
97 reimbursement request; or

98 6. Reverse and resubmit the claim of a pharmacist or pharmacy (i) without prior written notification to
99 the pharmacist or pharmacy, (ii) without just cause or attempt to first reconcile the claim with the pharmacist
100 or pharmacy, or (iii) more than 365 days after the claim was first affirmatively adjudicated;

101 7. Reduce any payment, directly or indirectly through a reconciliation process, to a pharmacist or
102 pharmacy for pharmacist services to an effective rate of reimbursement, including generic effective rates,
103 brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of
104 payment, unless agreed to by the pharmacist or pharmacy in the provider agreement;

105 8. Retroactively deny or reduce a claim or aggregate of claims unless (i) the original claim was submitted
106 fraudulently, (ii) the pharmacist or pharmacy has already been paid for the pharmacist services, or (iii) the
107 pharmacist services were not properly rendered by the pharmacist or pharmacy; or

108 9. Interfere with a covered individual's right to choose a pharmacy or provider, based on the pharmacy or
109 provider's status as a covered entity or contract pharmacy.

110 B. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a
111 pharmacy benefits manager, shall restrict participation of a pharmacy in a pharmacy network for provider
112 accreditation standards or certification requirements if a pharmacist meets such accreditation standards or
113 certification standards.

114 C. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a
115 pharmacy benefits manager, shall include any mail order pharmacy or pharmacy benefits manager affiliate in
116 calculating or determining network adequacy under any law or contract in the Commonwealth.

117 D. 1. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a
118 pharmacy benefits manager, shall conduct spread pricing in the Commonwealth.

119 2. Each carrier, on its own or through its contracted pharmacy benefits manager or representative of a
120 pharmacy benefits manager, shall (i) use the pass-through pricing model and (ii) if requested by the plan

121 sponsor, offer at least one contractual arrangement that limits income from pharmacy benefits management
122 services to income derived from pharmacy benefits management fees for services provided. The amount of
123 any pharmacy benefits management fees under such a contractual arrangement shall be set forth in the
124 agreement between the pharmacy benefits manager and carrier or health benefit plan.

125 3. If the contractual arrangement between the pharmacy benefits manager and carrier or health benefit
126 plan delegates the negotiation of rebates to the pharmacy benefits manager or an affiliated entity, the
127 pharmacy benefits manager shall direct 100 percent of all prescription drug manufacturer rebates received
128 to (i) the carrier or health benefit plan for offsetting defined cost sharing, deductibles, and coinsurance
129 contributions and reducing premiums of covered individuals or (ii) the covered individual at the point of sale
130 to reduce such individual's applicable deductible, copayment, coinsurance, or other cost-sharing amount.

131 4. The provisions of this subsection shall not prohibit a carrier or health benefit plan from paying
132 performance bonuses to a pharmacy benefits manager or network pharmacy based on savings to the payer
133 that decrease premiums paid by the covered individual or that result in covered individuals paying the lowest
134 level of cost sharing, deductibles, and coinsurance for a drug, as long as the performance bonus is not based
135 or contingent on (i) the acquisition or ingredient cost of a drug; (ii) the amount of savings, rebates, or other
136 fees charged, realized, or collected by, or generated based on the activity of, the pharmacy benefits manager
137 or its pharmacy benefits manager affiliates that is retained by the pharmacy benefits manager; or (iii) the
138 amount of premiums, deductibles, or other cost sharing or fees charged, realized, or collected by the
139 pharmacy benefits manager or its pharmacy benefits manager affiliates from patients or other persons on
140 behalf of a patient, except for performance bonuses that are based or contingent on a decrease in premiums,
141 deductibles, or other cost sharing.

142 5. Compensation arrangements governed by this subsection shall be open for inspection by the
143 Commission.

144 E. The termination of a provider contract with a pharmacy that is not a pharmacy benefits manager
145 affiliate shall not release a carrier or pharmacy benefits manager from the obligation to make any payment
146 due to the pharmacy for an affirmatively adjudicated claim unless any such payment is withheld in relation to
147 an investigation related to insurance fraud.

148 F. Each carrier on its own or through its contracted pharmacy benefits manager or representative of a
149 pharmacy benefits manager shall comply with the provisions of this section in addition to complying with the
150 provisions of § 38.2-3407.15:1.

151 § 38.2-3468. Examination of books and records; reports; access to records; report.

152 A. Each carrier, on its own or through its contract for pharmacy benefits, shall ensure that the
153 Commissioner may examine or audit the books and records of a pharmacy benefits manager providing claims
154 processing services or other prescription drug or device services for a carrier that are relevant to determining
155 if the pharmacy benefits manager is in compliance with this article. The carrier shall be responsible for the
156 charges incurred in the examination, including the expenses of the Commissioner or his designee and the
157 expenses and compensation of his examiners and assistants.

158 B. Each carrier, on its own or through its contract for pharmacy benefits, shall report the following
159 information to the Commissioner for each health benefit plan:

- 160 1. The aggregate amount of rebates received by the pharmacy benefits manager;
- 161 2. The aggregate amount of rebates distributed to the appropriate health benefit plan;
- 162 3. The aggregate amount of rebates passed on to the enrollees of each health benefit plan at the point of
163 sale that reduced the enrollees' applicable deductible, copayment, coinsurance, or other cost-sharing amount;
- 164 4. The aggregate amount of the pharmacy benefits manager's retained rebates;
- 165 5. The pharmacy benefits manager's aggregate retained rebate percentage;
- 166 6. The aggregate amount of administrative fees received by the pharmacy benefits manager;
- 167 7. Upon the request of the Commission, the individual and aggregate amount paid by the health benefit
168 plan to the pharmacy benefits manager for services itemized by pharmacy, by product, and by goods and
169 services; and
- 170 8. Upon the request of the Commission, the individual and aggregate amount a pharmacy benefits
171 manager paid for services itemized by pharmacy, by product, and by goods and services.

172 *C. In addition to the information required by subsection B, the third-party administrator for the state
173 employee health plan established pursuant to § 2.2-2818 or its pharmacy benefits manager shall report to the
174 Commissioner information regarding its pricing and maximum acquisition cost methodologies, including a
175 detailed explanation of how pharmacy reimbursement amounts are calculated, updated, and adjusted.*

176 *D. The annual report required by this subsection section shall be filed on a quarterly basis through March
177 31, 2023. The final quarterly report shall include information for the period ending December 31, 2022.
178 Thereafter, by March 31 of each year, the report shall be filed on a calendar year basis. The 2023 calendar
179 year report shall be filed by March 31, 2024.*

180 *E. All working papers, documents, reports, and copies thereof, produced by, obtained by or disclosed
181 to the Commission or any other person in the course of an examination made under this article and any*

182 analysis of such information or documents shall be given confidential treatment, are not subject to subpoena,
183 and may not be made public by the Commission or any other person. Access may also be granted to (i) a
184 regulatory official of any state or country; (ii) the National Association of Insurance Commissioners (NAIC),
185 its affiliate, or its subsidiary; or (iii) a law-enforcement authority of any state or country, provided that those
186 officials are required under their law to maintain its confidentiality. Any such disclosure by the Commission
187 shall not constitute a waiver of confidentiality of such papers, documents, reports or copies thereof. Any
188 parties receiving such papers must agree in writing prior to receiving the information to provide to it the same
189 confidential treatment as required by this section.

190 *F. The Commission shall annually prepare a report based on the information submitted pursuant to this*
191 *section, information submitted to a nonprofit organization, as defined in § 32.1-276.3, including information*
192 *submitted pursuant to § 38.2-3407.15:6, and any other information the Commission deems relevant, that*
193 *examines the overall impact of prescription drug costs on health care premiums in the Commonwealth. Such*
194 *report shall only contain aggregated data and shall not contain information that would cause financial,*
195 *competitive, or proprietary harm to any individual carrier or pharmacy benefits manager. The Commission*
196 *shall submit such report to the Governor and the General Assembly by September 30 of each year.*

197 **§ 38.2-3470. Scope of article.**

198 This article shall not apply with respect to claims under (i) an employee welfare benefit plan as defined in
199 section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1), that is
200 self-insured or self-funded; (ii) coverages issued pursuant to Title XIX of the Social Security Act, 42 U.S.C. §
201 1396 et seq. (Medicaid); or (iii) prescription drug coverages issued pursuant to Part D of Title XVIII of the
202 Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare Part D). *This article shall apply with respect to*
203 *claims under the state employee health plan established pursuant to § 2.2-2818.*

204 **2. That the provisions of the first enactment of this act shall become effective on July 1, 2027.**

205 **3. That the State Corporation Commission (the Commission) shall examine the practice of carriers or**
206 **pharmacy benefits managers, as those terms are defined in § 38.2-3465 of the Code of Virginia, as**
207 **amended by this act, requiring or inducing covered individuals to utilize pharmacy services at a**
208 **pharmacy benefits manager affiliate, as defined in § 38.2-3465 of the Code of Virginia, as amended by**
209 **this act. The Commission shall report its findings and recommendations to the General Assembly by**
210 **December 1, 2026.**