26106220D

SENATE BILL NO. 669

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Commerce and Labor on January 26, 2026)

(Patrons Prior to Substitute—Senators Rouse and Peake [SBs 410 and 413])

A BILL to amend and reenact §§ 38.2-3465, 38.2-3467, 38.2-3468, and 38.2-3470 of the Code of Virginia, relating to pharmacy benefits managers; requirements; application of law; report.

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3465, 38.2-3467, 38.2-3468, and 38.2-3470 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-3465. Definitions.

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

"Aggregate retained rebate percentage" means the sum total dollar amount of a pharmacy benefits manager's retained rebates relating to all carrier clients of such pharmacy benefits manager divided by the sum total dollar amount of all rebates received by such pharmacy benefits manager relating to all such clients.

"Carrier" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15. However, "carrier" does not include a nonprofit health maintenance organization that operates as a group model whose internal pharmacy operation exclusively serves the members or patients of the nonprofit health maintenance organization.

"Claim" means a request from a pharmacy or pharmacist to be reimbursed for the cost of administering, filling, or refilling a prescription for a drug or for providing a medical supply or device.

"Claims processing services" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include (i) receiving payments for pharmacist services, (ii) making payments to pharmacists or pharmacies for pharmacist services, or (iii) both receiving and making payments.

"Contract pharmacy" means a pharmacy operating under contract with a 340B-covered entity to provide dispensing services to the 340B-covered entity, as described in 75 Fed. Reg. 10272 (March 5, 2010) or any superseding guidance published thereafter.

"Covered entity" means an entity described in § 340B(a)(4) of the federal Public Health Service Act, 42 U.S.C. § 256B(a)(4).

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

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

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

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

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

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

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

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

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

"Rebate" means a discount or other price concession, including without limitation incentives, disbursements, and reasonable estimates of a volume-based discount, or a payment that is (i) based on utilization of a prescription drug and (ii) paid by a manufacturer or third party, directly or indirectly, to a pharmacy benefits manager, pharmacy services administrative organization, or pharmacy after a claim has been processed and paid at a pharmacy.

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

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

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

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

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

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

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

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

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

4. Penalize or retaliate against a pharmacist or pharmacy for exercising rights provided pursuant to the provisions of this article*, including penalizing or retaliating by (i) terminating or refusing to renew a contract with the pharmacist or pharmacy, (ii) subjecting the pharmacist or pharmacy to increased audits without cause, or (iii) failing to promptly pay the pharmacist or pharmacy money owed to such pharmacist or pharmacy*;

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

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

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

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

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

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

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

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

2. Each carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall (i) use the pass-through pricing model and (ii) if requested by the plan sponsor, offer at least one contractual arrangement that limits income from pharmacy benefits management

services to income derived from pharmacy benefits management fees for services provided. The amount of any pharmacy benefits management fees under such a contractual arrangement shall be set forth in the agreement between the pharmacy benefits manager and carrier or health benefit plan.

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

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

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

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

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

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

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

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

1. The aggregate amount of rebates received by the pharmacy benefits manager;

2. The aggregate amount of rebates distributed to the appropriate health benefit plan;

3. The aggregate amount of rebates passed on to the enrollees of each health benefit plan at the point of sale that reduced the enrollees' applicable deductible, copayment, coinsurance, or other cost-sharing amount;

4. The aggregate amount of the pharmacy benefits manager's retained rebates;

5. The pharmacy benefits manager's aggregate retained rebate percentage;

6. The aggregate amount of administrative fees received by the pharmacy benefits manager;

7. Upon the request of the Commission, the individual and aggregate amount paid by the health benefit plan to the pharmacy benefits manager for services itemized by pharmacy, by product, and by goods and services; and

8. Upon the request of the Commission, the individual and aggregate amount a pharmacy benefits manager paid for services itemized by pharmacy, by product, and by goods and services.

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

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

~~C.~~ *E.* All working papers, documents, reports, and copies thereof, produced by, obtained by or disclosed to the Commission or any other person in the course of an examination made under this article and any analysis of such information or documents shall be given confidential treatment, are not subject to subpoena, and may not be made public by the Commission or any other person. Access may also be granted to (i) a

regulatory official of any state or country; (ii) the National Association of Insurance Commissioners (NAIC), its affiliate, or its subsidiary; or (iii) a law-enforcement authority of any state or country, provided that those officials are required under their law to maintain its confidentiality. Any such disclosure by the Commission shall not constitute a waiver of confidentiality of such papers, documents, reports or copies thereof. Any parties receiving such papers must agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section.

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

§ 38.2-3470. Scope of article.

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

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

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