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HOUSE BILL NO. 483
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the Governor
on April 13, 2026)

(Patron Prior to Substitute—Delegate Delaney)

A *BILL to amend and reenact §§ 32.1-276.3 and 32.1-276.7:1 of the Code of Virginia and to amend the Code of Virginia by adding in Title 32.1 a chapter numbered 7.3, consisting of sections numbered 32.1-276.12, 32.1-276.13, and 32.1-276.14, and by adding in Article 1 of Chapter 34 of Title 54.1 a section numbered 54.1-3431.1, relating to prescription drug affordability advisory panel established; maximum fair price; annual reports; civil penalties; report.*

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-276.3 and 32.1-276.7:1 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Title 32.1 a chapter numbered 7.3, consisting of sections numbered 32.1-276.12, 32.1-276.13, and 32.1-276.14, and by adding in Article 1 of Chapter 34 of Title 54.1 a section numbered 54.1-3431.1 as follows:

§ 32.1-276.3. Definitions.

As used in this chapter:

"Actual reimbursement amount" means reimbursement information included in the claims data submitted by data suppliers to the Virginia All-Payer Claims Database, whether such information is referred to in the claims data as "paid amounts," "allowed amounts," or another term having the same or similar meaning and whether in reference to the payer who paid the actual reimbursement amount or the provider who received the actual reimbursement amount.

"Board" means the Board of Health.

"Common data layout" means the national data collection standard adopted and maintained by the APCD Council.

"Consumer" means any person (i) whose occupation is other than the administration of health activities or the provision of health services, (ii) who has no fiduciary obligation to a health care institution or other health agency or to any organization, public or private, whose principal activity is an adjunct to the provision of health services, or (iii) who has no material financial interest in the rendering of health services.

"Covered lives" means subscribers, policyholders, members, enrollees, or dependents, as the case may be, under a policy or contract issued or issued for delivery in Virginia by a managed care health insurance plan licensee, insurer, health services plan, or preferred provider organization.

"ERISA plan" means any self-funded employee welfare benefit plan governed by the requirements of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1).

"Health care provider" means (i) a general hospital, ordinary hospital, outpatient surgical hospital, nursing home or certified nursing facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title; (ii) a mental or psychiatric hospital licensed pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2; (iii) a hospital operated by the Department of Behavioral Health and Developmental Services; (iv) a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority; (v) any person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1; (vi) any person licensed to furnish health care policies or plans pursuant to Chapter 34 (§ 38.2-3400 et seq.), Chapter 42 (§ 38.2-4200), or Chapter 43 (§ 38.2-4300) of Title 38.2; or (vii) any person licensed to practice dentistry pursuant to Chapter 27 (§ 54.1-2700 et seq.) of Title 54.1 who is registered with the Board of Dentistry as an oral and maxillofacial surgeon and certified by the Board of Dentistry to perform certain procedures pursuant to § 54.1-2709.1. In no event shall such term be construed to include continuing care retirement communities which file annual financial reports with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 or any nursing care facility of a religious body which depends upon prayer alone for healing.

"Health maintenance organization" means any person who undertakes to provide or to arrange for one or more health care plans pursuant to Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2.

"Inpatient hospital" means a hospital providing inpatient care and licensed pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5, a hospital licensed pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2, a hospital operated by the Department of Behavioral Health and Developmental Services for the care and treatment of individuals with mental illness, or a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority.

"Non-claims payment data" means payment and rebate data that does not necessarily originate from a claim, including incentive payments, capitation payments, rebates that a carrier received from a drug manufacturer, and data elements consistent with national standards for non-claims-based payment data collection.

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60 "Nonprofit organization" means a nonprofit, tax-exempt health data organization with the characteristics,
61 expertise, and capacity to execute the powers and duties set forth for such entity in this chapter.

62 "Oral and maxillofacial surgeon" means, for the purposes of this chapter, a person who is licensed to
63 practice dentistry in Virginia, registered with the Board of Dentistry as an oral and maxillofacial surgeon, and
64 certified to perform certain procedures pursuant to § 54.1-2709.1.

65 "Oral and maxillofacial surgeon's office" means a place (i) owned or operated by a licensed and registered
66 oral and maxillofacial surgeon who is certified to perform certain procedures pursuant to § 54.1-2709.1 or by
67 a group of oral and maxillofacial surgeons, at least one of whom is so certified, practicing in any legal form
68 whatsoever or by a corporation, partnership, limited liability company or other entity that employs or engages
69 at least one oral and maxillofacial surgeon who is so certified, and (ii) designed and equipped for the
70 provision of oral and maxillofacial surgery services to ambulatory patients.

71 "Outpatient surgery" means all surgical procedures performed on an outpatient basis in a general hospital,
72 ordinary hospital, outpatient surgical hospital or other facility licensed or certified pursuant to Article 1
73 (§ 32.1-123 et seq.) of Chapter 5 of this title or in a physician's office or oral and maxillofacial surgeon's
74 office, as defined above. Outpatient surgery refers only to those surgical procedure groups on which data are
75 collected by the nonprofit organization as a part of a pilot study.

76 "Physician" means a person licensed to practice medicine or osteopathy in the Commonwealth pursuant to
77 Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1.

78 "Physician's office" means a place (i) owned or operated by a licensed physician or group of physicians
79 practicing in any legal form whatsoever or by a corporation, partnership, limited liability company or other
80 entity that employs or engages physicians and (ii) designed and equipped solely for the provision of
81 fundamental medical care, whether diagnostic, therapeutic, rehabilitative, preventive or palliative, to
82 ambulatory patients.

83 "Surgical procedure group" means at least five procedure groups, identified by the nonprofit organization
84 designated pursuant to § 32.1-276.4 in compliance with regulations adopted by the Board, based on criteria
85 that include, but are not limited to, the frequency with which the procedure is performed, the clinical severity
86 or intensity, and the perception or probability of risk. The nonprofit organization shall form a technical
87 advisory group consisting of members nominated by its Board of Directors' nominating organizations to
88 assist in selecting surgical procedure groups to recommend to the Board for adoption.

89 "System" means the Virginia Patient Level Data System.

90 **§ 32.1-276.7:1. All-Payer Claims Database created; purpose; reporting requirements.**

91 A. The Virginia All-Payer Claims Database is hereby created to facilitate data-driven, evidence-based
92 improvements in access, quality, and cost of health care and to promote and improve the public health
93 through the understanding of health care expenditure patterns and operation and performance of the health
94 care system.

95 B. The Commissioner shall ensure that the Department meets the requirements to be a health oversight
96 agency as defined in 45 C.F.R. § 164.501.

97 C. The Commissioner, in cooperation with the Bureau of Insurance, shall collect paid claims *and non-*
98 *claims payment* data for covered benefits from data suppliers, which shall include:

99 1. Issuers of individual or group accident and sickness insurance policies providing hospital, medical and
100 surgical, or major medical coverage on an expense-incurred basis; corporations providing individual or group
101 accident and sickness subscription contracts; and health maintenance organizations providing a health care
102 plan for health care services, for at least 1,000 covered lives in the most recent calendar year;

103 2. Third-party administrators and any other entities that receive or collect charges, contributions, or
104 premiums for, or adjust or settle health care claims for, at least 1,000 Virginia covered lives on behalf of
105 group health plans other than ERISA plans;

106 3. Third-party administrators, and any other entities, that receive or collect charges, contributions, or
107 premiums for, or adjust or settle health care claims for, an employer that maintains an ERISA plan that has
108 opted-in to data submission to the All-Payer Claims Database pursuant to subsection P;

109 4. The Department of Medical Assistance Services with respect to services provided under programs
110 administered pursuant to Titles XIX and XXI of the Social Security Act;

111 5. State government health insurance plans;

112 6. Local government health insurance plans, subject to their ability to provide such data and to the extent
113 permitted by state and federal law; and

114 7. Federal health insurance plans, to the extent permitted by federal law, including Medicare, TRICARE,
115 and the Federal Employees Health Benefits Plan.

116 Such collection of paid claims *and non-claims payment* data for covered benefits shall not include data
117 related to Medigap, disability income, workers' compensation claims, standard benefits provided by
118 long-term care insurance, disease specific health insurance, dental or vision claims, or other supplemental
119 health insurance products;

120 D. The Commissioner shall ensure that the nonprofit organization executes a standard data submission
121 and use agreement with each entity listed in subsection B that submits paid claims *and non-claims payment*

122 data to the All-Payer Claims Database and each entity that subscribes to data products and reports. Such
 123 agreements shall include procedures for submission, collection, aggregation, and distribution of specified
 124 data. Additionally, the Commissioner shall ensure that the nonprofit organization:

125 1. Protects patient privacy and data security pursuant to provisions of this chapter and state and federal
 126 privacy laws, including the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et
 127 seq., as amended); Titles XIX and XXI of the Social Security Act; § 32.1-127.1:03; Chapter 6 (§ 38.2-600 et
 128 seq.) of Title 38.2; and the Health Information Technology for Economic and Clinical Health (HITECH) Act,
 129 as included in the American Recovery and Reinvestment Act (P.L. 111-5, 123 Stat. 115) as if the nonprofit
 130 organization were covered by such laws;

131 2. Identifies the type of paid claims *and non-claims payment data* to be collected by the All-Payer Claims
 132 Database and the entities that are subject to the submission of such claims as well as identification of specific
 133 data elements from existing claims systems to be submitted and collected, including but not limited to patient
 134 demographics, diagnosis and procedure codes, provider information, plan payments, member payment
 135 responsibility, and service dates;

136 3. Administers the All-Payer Claims Database in a manner to allow for geographic, demographic,
 137 economic, and peer group comparisons;

138 4. Develops public analyses identifying and comparing health plans by public and private health care
 139 purchasers, providers, employers, consumers, health plans, health insurers, and data analysts, health insurers,
 140 and providers with regard to their provision of safe, cost-effective, and high-quality health care services;

141 5. Uses common data layout or other national data collection standards and methods that utilize a standard
 142 set of core data elements for data submissions, as adopted or endorsed by the APCD Council, to establish and
 143 maintain the database in a cost-effective manner and to facilitate uniformity among various all-payer claims
 144 databases of other states and specification of data fields to be included in the submitted claims, consistent
 145 with such national standards, allowing for exemptions when submitting entities do not collect the specified
 146 data or pay on a per-claim basis, such exemption process to be managed by the advisory committee created
 147 pursuant to subsection E;

148 6. Does not disclose or report provider-specific, facility-specific, or carrier-specific reimbursement
 149 information, or information capable of being reverse-engineered, combined, or otherwise used to calculate or
 150 derive such reimbursement information, from the All-Payer Claims Database;

151 7. Promotes the responsible use of claims data to improve health care value and preserve the integrity and
 152 utility of the All-Payer Claims Database; ~~and~~

153 8. Requires that all public reports and analyses comparing providers or health plans using data from the
 154 All-Payer Claims Database use national standards or, when such national standards are unavailable, provide
 155 full transparency to providers or health plans of the alternative methodology used; *and*

156 9. *Provides an annual report to the Prescription Drug Affordability Advisory Panel established pursuant*
 157 *to § 32.1-276.12 on each prescription drug (i) for which, during the preceding calendar year, (a) the price*
 158 *increased by 10 percent or more or (b) rebate amounts decreased by 10 percent or more; (ii) that is*
 159 *designated as a high-cost drug by the Department of Medical Assistance Services; or (iii) that is subject to*
 160 *reporting requirements set forth in § 54.1-3442.02.*

161 E. The Commissioner shall establish an advisory committee to assist in the formation and operation of the
 162 All-Payer Claims Database. Such committee shall consist of (i) a representative from each of the following: a
 163 statewide hospital association, a statewide association of health plans, a professional organization
 164 representing physicians, a professional organization representing pharmacists, an organization that processes
 165 insurance claims or certain aspects of employee benefits plans for a separate entity, a community mental
 166 health center who has experience in behavioral health data collection, a nursing home health care provider
 167 who has experience with medical claims data, a nonprofit health insurer, and a for-profit health insurer; (ii)
 168 up to two representatives with a demonstrated record of advocating health care issues on behalf of
 169 consumers; (iii) two representatives of hospitals or health systems; (iv) an individual with academic
 170 experience in health care data and cost-efficiency research; (v) a representative who is not a supplier or
 171 broker of health insurance from small employers that purchase group health insurance for employees; (vi) a
 172 representative who is not a supplier or broker of health insurance from large employers that purchase health
 173 insurance for employees, and (vii) a representative who is not a supplier or broker of health insurance from
 174 self-insured employers, all of whom shall be appointed by the Commissioner. The Commissioner, the
 175 chairman of the board of directors of the nonprofit organization, the Commissioner of Insurance, the Director
 176 of the Department of Medical Assistance Services, the Director of the Department of Human Resource
 177 Management, or their designees, shall serve *ex officio*.

178 In appointing members to the advisory committee, the Commissioner shall adopt reasonable measures to
 179 select representatives in a manner that provides balanced representation within and among the appointments
 180 and that any representative appointed is without any actual or apparent conflict of interest, including conflicts
 181 of interest created by virtue of the individual's employer's corporate affiliations or ownership interests.

182 The nonprofit organization shall provide the advisory committee with details at least annually on the use
 183 and disclosure of All-Payer Claims Database data, including reports developed by the nonprofit organization;

184 details on methods used to extract, transform, and load data; and efforts to protect patient privacy and data
185 security.

186 The meetings of the advisory committee shall be open to the public.

187 F. The Commissioner shall establish a data release committee to review and approve requests for access to
188 data. The data release committee shall consist of the Commissioner or his designee, and upon
189 recommendation of the advisory committee, the Commissioner shall appoint an individual with academic
190 experience in health care data and cost-efficiency research; a representative of a health insurer; a health care
191 practitioner; a representative from a hospital with a background in administration, analytics, or research; and
192 a representative with a demonstrated record of advocating health care issues on behalf of consumers. In
193 making its recommendations, the advisory committee shall adopt reasonable measures to select
194 representatives in a manner that provides balanced representation within and among the appointments and
195 that any representative appointed is without any actual or apparent conflict of interest, including conflicts of
196 interest created by virtue of the individual's employer's corporate affiliations or ownership interests. The data
197 release committee shall ensure that (i) all data approvals are consistent with the purposes of the All-Payer
198 Claims Database as provided in subsection A; (ii) all data approvals comply with applicable state and federal
199 privacy laws and state and federal laws regarding the exchange of price and cost information to protect the
200 confidentiality of the data and encourage a competitive marketplace for health care services; and (iii) the level
201 of detail, as provided in subsection H, is appropriate for each request and is accompanied by a standardized
202 data use agreement.

203 G. The nonprofit organization shall implement the All-Payer Claims Database, consistent with the
204 provisions of this chapter, to include:

205 1. The reporting of data that can be used to improve public health surveillance and population health,
206 including reports on (i) injuries; (ii) chronic diseases, including but not limited to asthma, diabetes,
207 cardiovascular disease, hypertension, arthritis, and cancer; (iii) health conditions of pregnant women, infants,
208 and children; and (iv) geographic and demographic information for use in community health assessment,
209 prevention education, and public health improvement. This data shall be developed in a format that allows
210 comparison of information in the All-Payer Claims Database with other nationwide data programs and that
211 allows employers to compare their employee health plans statewide and between and among regions of the
212 Commonwealth and nationally.

213 2. The reporting of data that payers, providers, and health care purchasers, including employers and
214 consumers, may use to compare quality and efficiency of health care, including development of information
215 on utilization patterns and information that permits comparison of health plans and providers statewide
216 between and among regions of the Commonwealth. The advisory committee created pursuant to subsection E
217 shall make recommendations to the nonprofit organization on the appropriate level of specificity of reported
218 data in order to protect patient privacy and to accurately attribute services and resource utilization rates to
219 providers.

220 3. The reporting of data that permits design and evaluation of alternative delivery and payment models.

221 4. The reporting and release of data consistent with the purposes of the All-Payer Claims Database as set
222 forth in subsection A as determined to be appropriate by the data release committee created pursuant to
223 subsection F.

224 H. Except as provided in subsection O, the nonprofit organization shall not provide data or access to data
225 without the approval of the data release committee. Upon approval, the nonprofit organization may provide
226 data or access to data at levels of detail that may include (i) aggregate reports, which are defined as data
227 releases with all observation counts greater than 10; (ii) de-identified data sets that meet the standard set forth
228 in 45 C.F.R. § 164.514(a); and (iii) limited data sets that comply with the National Institutes of Health
229 guidelines for release of personal health information.

230 I. Reporting of data shall not commence until such data has been processed and verified at levels of
231 accuracy consistent with existing nonprofit organization data standards. Prior to public release of any report
232 specifically naming any provider or payer, or public reports in which an individual provider or payers
233 represents 60 percent or more of the data, the nonprofit organization shall provide affected entities with
234 notice of the pending report and allow for a 30-day period of review to ensure accuracy. During this period,
235 affected entities may seek explanations of results and correction of data that they prove to be inaccurate. The
236 nonprofit organization shall make these corrections prior to any public release of the report. At the end of the
237 review period, upon completion of all necessary corrections, the report may be released. For the purposes of
238 this subsection, "public release" means the release of any report to the general public and does not include the
239 preparation of reports for, or use of the All-Payer Claims Database by, organizations that have been approved
240 for access by the data release committee and have entered into written agreements with the nonprofit
241 organization.

242 J. The Commissioner and the nonprofit organization shall consider and recommend, as appropriate,
243 integration of new data sources into the All-Payer Claims Database, based on the findings and
244 recommendations of the advisory committee.

245 K. Information acquired pursuant to this section shall be confidential and shall be exempt from disclosure

246 by the Virginia Freedom of Information Act (§ 2.2-3700 et seq.). The reporting and release of data pursuant
 247 to this section shall comply with all state and federal privacy laws and state and federal laws regarding the
 248 exchange of price and cost information to protect the confidentiality of the data and encourage a competitive
 249 marketplace for health care services.

250 L. No person shall assess costs or charge a fee to any health care practitioner related to formation or
 251 operation of the All-Payer Claims Database. However, a reasonable fee may be charged to health care
 252 practitioners who voluntarily access the All-Payer Claims Database for purposes other than data verification.

253 M. As used in this section, "provider" means a hospital or physician as defined in this chapter or any other
 254 health care practitioner licensed, certified, or authorized under state law to provide covered services
 255 represented in claims reported pursuant to this section.

256 N. The Commissioner, in consultation with the board of directors of the nonprofit organization, shall
 257 develop short-term and long-term funding strategies for the operation of the All-Payer Claims Database to
 258 provide necessary funding in excess of any budget appropriation by the Commonwealth.

259 O. The nonprofit organization, the Department of Health, the Department of Medical Assistance Services,
 260 ~~and~~ the Bureau of Insurance, *the Prescription Drug Affordability Advisory Panel, and the Office of the*
 261 *Attorney General* shall have access to data reported by the All-Payer Claims Database pursuant to this section
 262 at no cost for the purposes of public health improvement research and activities *and legal enforcement. The*
 263 *Office of the Attorney General and the Prescription Drug Affordability Advisory Panel shall also have*
 264 *access, upon request and subject to applicable state and federal privacy laws, to data and reports submitted*
 265 *to the nonprofit organization pursuant to § 54.1-3442.02 for the purposes of analysis, oversight, and*
 266 *enforcement. The Attorney General may utilize any data or information obtained pursuant to this section or*
 267 *§ 54.1-3442.02 to enforce or further investigate violations of the Virginia Antitrust Act (§ 59.1-9.1 et seq.),*
 268 *the Virginia Consumer Protection Act (§ 59.1-196 et seq.), or any other applicable state or federal law.*

269 P. Each employer that maintains an ERISA plan may opt-in to allow a third-party ~~administer~~
 270 *administrator* or other entity to submit data to the All-Payer Claims Database. For any such employer that
 271 opts-in, the third-party administrator or other entity shall (i) submit data for the next reporting period after the
 272 opt-in and all future reporting periods until the employer opts-out and (ii) include data from any such
 273 employer as part of its data submission, if any, otherwise required by this section. Such an employer may
 274 opt-out at any time but shall provide written notice to the third-party administrator or other entity of its
 275 decision at least 30 days prior to the start of the next reporting period. No employer that maintains an ERISA
 276 plan shall be required to opt-in to data submission to the All-Payer Claims Database, and no third-party
 277 administrator or other entity shall be required to submit claims processed before it was contracted to provide
 278 services. Each third-party administrator or other entity providing claim administration services for an
 279 employer shall submit annually to the nonprofit organization by January 31 of each year a list of the ERISA
 280 plans whose employer has opted-in to data submission to the All-Payer Claims Database and a list identifying
 281 all employers that maintain an ERISA plan with Virginia employees for which it provides claim
 282 administration services. Such information submitted shall be considered proprietary and shall be exempt from
 283 disclosure by the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

284 Q. Any data release shall make use of a masked proxy reimbursement amount, for which the methodology
 285 is publicly available and approved by the data release committee except that the Department may request that
 286 the nonprofit organization generate the following reports based on actual reimbursement amounts: (i) the total
 287 cost burden of a disease, chronic disease, injury, or health condition across the state, health planning region,
 288 health planning district, county, or city, provided that the total cost shall be an aggregate amount
 289 encompassing costs attributable to all data suppliers and not identifying or attributable to any individual
 290 provider, and (ii) any analyses to determine the average reimbursement that is paid for health care services
 291 that may include inpatient and outpatient diagnostic services, surgical services or the treatment of certain
 292 conditions or diseases. Any additional report of analysis based on actual reimbursement amounts shall require
 293 the approval of the data release committee.

294 R. The nonprofit organization shall ensure the timely reporting of information by private data suppliers to
 295 meet the requirements of this section. The nonprofit organization shall notify private data suppliers of any
 296 applicable reporting deadlines. The nonprofit shall notify, in writing, a private data supplier of a failure to
 297 meet a reporting deadline, and that failure to respond within two weeks following receipt of the written notice
 298 may result in a penalty. The Board may assess a civil penalty of up to \$1,000 per week per violation, not to
 299 exceed a total of \$50,000 per violation, against a private data supplier that fails, within its determination, to
 300 make a good faith effort to provide the requested information within two weeks following receipt of the
 301 written notice required by this subsection. Civil penalties assessed under this subsection shall be maintained
 302 by the Department and used for the ongoing improvement of the All-Payer Claims Database.

303 CHAPTER 7.3.

304 AFFORDABLE MEDICINE ACT.

305 § 32.1-276.12. Prescription Drug Affordability Advisory Panel established; purpose; annual report.

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

307 "Panel" means the Prescription Drug Affordability Advisory Panel.

308 *"Secretary" means the Secretary of Health and Human Resources.*

309 *B. The Secretary shall establish the Prescription Drug Affordability Advisory Panel to conduct data*
310 *analyses, develop policy recommendations, and identify implementation barriers related to strategies to*
311 *improve prescription drug affordability, enhance price transparency, and strengthen data collection*
312 *practices for prescription drugs across public and private payers.*

313 *C. By December 31, 2026, and annually thereafter, the Panel shall submit to the Governor, the State*
314 *Corporation Commission, the Chairs of the Senate Committees on Commerce and Labor and Education and*
315 *Health, and the Chairs of the House Committees on Labor and Commerce and Health and Human Services a*
316 *report that includes (i) prescription drug pricing trends in the Commonwealth and (ii) any policy*
317 *recommendations on legislation to improve prescription drug affordability in the Commonwealth. The Panel*
318 *shall also publish quarterly updates on prescription drug pricing trends in the Commonwealth.*

319 **§ 32.1-276.13. Membership; chair and vice-chair; quorum; meetings.**

320 *A. The Panel shall have a total membership of seven members that shall consist of five nonlegislative*
321 *citizen members and two ex officio members. Nonlegislative citizen members shall be appointed by the*
322 *Governor. The Panel shall hire an executive director and may employ staff or contract with experts in the*
323 *field of prescription drug policy, affordability policy, or health data analytics, subject to available funding.*
324 *The executive director and any other Panel staff shall receive a salary as provided in the general*
325 *appropriation act. The Secretary or his designee and the Commissioner of the Bureau of Insurance or his*
326 *designee shall serve ex officio with nonvoting privileges. Nonlegislative citizen members of the Panel shall be*
327 *citizens of the Commonwealth.*

328 *The ex officio members of the Panel shall serve a term coincident with their term of office. Appointments*
329 *to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled*
330 *in the same manner as the original appointments. All members may be reappointed.*

331 *After the initial staggering of terms, nonlegislative citizen members shall be appointed for a term of four*
332 *years. No nonlegislative citizen member shall serve more than two consecutive four-year terms. The*
333 *remainder of any term to which a member is appointed to fill a vacancy shall not constitute a term in*
334 *determining the member's eligibility for reappointment.*

335 *B. Nonlegislative citizen members of the Panel shall have expertise in at least one of the following areas:*
336 *prescription drug pricing, drug discount programs, prescription drug contracting, patient out-of-pocket*
337 *expenditures, health insurance design, drug manufacturing, bulk purchasing, prescription drug data*
338 *collection and analytics, or prescription drug and health care policy.*

339 *C. The Panel shall elect a chair and vice-chair from among its membership. A majority of the members*
340 *shall constitute a quorum. The meetings of the Panel shall be held at the call of the chair or whenever the*
341 *majority of the members so request.*

342 **§ 32.1-276.14. Powers and duties of the Panel.**

343 *A. The Panel shall (i) meet quarterly to review prescription drug pricing, cost and utilization trends, and*
344 *trends in out-of-pocket payments; (ii) analyze drug transparency data; and (iii) report annually pursuant to*
345 *subsection C of § 32.1-276.12 on topics and information, including:*

346 *1. Public and private sector drug price trends;*

347 *2. Out-of-pocket costs for patients in the Commonwealth related to prescription drug expenses;*

348 *3. Opportunities to enhance transparency in reporting prescription drug prices and any rebates,*
349 *discounts, or price concessions;*

350 *4. Methods for the Department of Medical Assistance Services to best utilize the best price provisions of*
351 *the Medicaid drug rebate program under 42 C.F.R. § 447.509 to increase savings to the Commonwealth;*

352 *5. Strategies for local governments to reduce spending on prescription drugs;*

353 *6. Opportunities to improve the Commonwealth's data collection and reporting systems, including*
354 *standardized electronic reporting formats; and*

355 *7. Suggested statutory or regulatory changes to improve affordability and transparency.*

356 *B. All recommendations issued by the Panel shall be provided in the report required pursuant to*
357 *subsection C of § 32.1-276.12.*

358 **§ 54.1-3431.1. Maximum fair prices for certain prescription drugs; civil penalties.**

359 *A. As used in this section:*

360 *"Commissioner" means the State Health Commissioner.*

361 *"Department" means the Department of Health.*

362 *"ERISA plan" means an employee welfare benefit plan as defined in § 3(1) of the federal Employee*
363 *Retirement Income Security Act of 1974.*

364 *"Generic drug" means (i) a retail drug that is marketed or distributed in accordance with an abbreviated*
365 *new drug application approved under 21 U.S.C. § 355(j), (ii) an authorized generic drug as defined by 42*
366 *C.F.R. § 447.502, or (iii) a drug that entered the market before 1962 that was not originally marketed under*
367 *a new drug application.*

368 *"Health plan" means an individual or group plan that provides, or pays the cost of, medical care. "Health*
369 *plan" includes any entity included in such definition as set out in 45 C.F.R. § 160.103.*

370 "Maximum fair price" means the maximum fair price established for a prescription drug by the U.S.
 371 Secretary of Health and Human Services pursuant to 42 U.S.C. § 1320f-3.

372 "Panel" means the Prescription Drug Affordability Advisory Panel established pursuant to § 32.1-276.12.

373 "Participating ERISA plan" means an ERISA plan that elects to be subject to maximum fair prices
 374 pursuant to this section.

375 "Pharmacy benefits manager" means the same as that term is defined in § 38.2-3465.

376 "Price applicability period" means the same as that term is defined in 42 U.S.C. § 1320f(b)(2).

377 "Referenced drug" means a prescription drug subject to a maximum fair price. "Referenced drug" does
 378 not include (i) any brand-name prescription drug or biologic that is designated for a rare disease or
 379 condition under 21 U.S.C. § 360bb and for which the only approved indication is for one or more rare
 380 diseases or conditions or (ii) any biological product that is derived from human blood or plasma.

381 "State entity" means any agency of state government that purchases or reimburses payers for prescription
 382 drugs on behalf of the Commonwealth for any person whose health care is paid for by the Commonwealth,
 383 including any agent, vendor, contractor, or other party acting on behalf of the Commonwealth. "State entity"
 384 does not include the medical assistance programs established pursuant to Title XIX of the Social Security Act,
 385 42 U.S.C. § 1396 et seq., or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq.

386 B. Each pharmacy benefits manager shall provide to the Panel, upon request, financial information,
 387 including administrative fees, formulary management fees, rebate retention, network access fees, shared
 388 savings programs, and the total and final payment details, including the ingredient cost and any dispensing
 389 fee, paid or payable by the pharmacy benefits manager to a pharmacy for dispensing a referenced drug. Such
 390 information shall include all associated fees, adjustments, and reconciliations. No information disclosed by a
 391 pharmacy benefit manager, an affiliate of a pharmacy benefit manager, a plan, or a pharmacy under this
 392 subsection that is not otherwise publicly available or available for purchase shall be disclosed by the Panel,
 393 except that the Panel may disclose such information as the Panel determines necessary to carry out its
 394 purposes and to the Department for purposes of oversight and enforcement of this section. However, neither
 395 the Panel nor the Department shall report on or disclose such information to the public in a manner that
 396 would identify (i) a specific pharmacy benefits manager, affiliate, pharmacy, manufacturer, wholesale
 397 distributor, or health plan or (ii) contract prices, rebates, discounts, or other remuneration for specific
 398 referenced drugs in a manner that would allow the identification of specific contracting parties or referenced
 399 drugs.

400 C. No manufacturer or wholesale distributor permitted or licensed pursuant to this chapter shall accept
 401 payment at an amount higher than the maximum fair price for the sale of a referenced drug intended for use
 402 by individuals in the Commonwealth in person, by mail, or by any other means, plus any applicable
 403 pharmacy dispensing fees and provider administration fees. No pharmacy licensed in the Commonwealth
 404 shall be reimbursed for a referenced drug at an amount less than the maximum fair price or the national
 405 acquisition cost, whichever is greater, plus the required dispensing fee for such referenced drug as
 406 established by the cost dispensing survey required by 12VAC30-80-40. No provision of this section shall be
 407 construed to prevent a pharmacy from receiving a dispensing fee above the maximum fair price for a
 408 referenced drug.

409 D. An ERISA plan may elect to be subject to the provisions of this section by notifying the Panel in writing
 410 by January 1 of each calendar year.

411 E. Each health plan regulated under the laws of the Commonwealth shall inform the Panel of how the cost
 412 savings related to the maximum fair price pursuant to this section are directed to the benefit of enrollees with
 413 a priority on enrollee cost-sharing. Any savings generated by a health plan, state entity, or participating
 414 ERISA plan that are attributable to the implementation of the maximum fair price pursuant to this section
 415 shall be used to reduce costs to consumers, prioritizing the reduction of out-of-pocket costs for prescription
 416 drugs. On or before April 1 of each calendar year, each health plan, state entity, and participating ERISA
 417 plan shall submit to the Panel a report describing the savings achieved as a result of implementing the
 418 maximum fair price and how those savings were used to reduce costs to consumers.

419 F. No manufacturer subject to the provisions of this section shall remove a referenced drug from sale or
 420 distribution within the Commonwealth for the purpose of avoiding the impact of the rate limitations set forth
 421 in this section unless such manufacturer provides a written notice of withdrawal to the Panel and the
 422 Department within 180 days prior to such withdrawal.

423 G. The Commissioner shall assess a penalty on any manufacturer that he determines has withdrawn a
 424 referenced drug from sale or distribution in the Commonwealth in violation of subsection F. With respect to
 425 each referenced drug withdrawn by such manufacturer, such civil penalty shall be equal to the greater of (i)
 426 \$100,000 or (ii) the total amount of annual savings for the referenced drug, as determined by the Panel
 427 pursuant to subsection E.

428 H. Except as provided in subsections F and G, an entity that violates any provision of this section shall be
 429 subject to a civil penalty of \$10,000 per violation. Each transaction in violation of any provision of this
 430 section shall constitute a separate violation for purposes of this subsection. The Commissioner is authorized
 431 to enforce the provisions of this section, and any penalty assessed pursuant to this section shall be deposited

432 *into the Literary Fund. Any person aggrieved by a penalty assessed pursuant to this section shall be entitled*
433 *to judicial review thereof in accordance with the Administrative Process Act (§ 2.2-4000 et seq.).*

434 *I. The Board of Health and the Board may adopt any regulations necessary to implement the requirements*
435 *of this section.*

436 **2. That the initial appointments of nonlegislative citizen members by the Governor shall be staggered**
437 **as follows: one member for a term of two years, two members for a term of three years, and two**
438 **members for a term of four years.**

439 **3. That the provisions of § 54.1-3431.1 of the Code of Virginia, as created by this act, shall not become**
440 **effective unless reenacted by the 2027 Session of the General Assembly.**

441 **4. That, by December 31, 2026, the Prescription Drug Affordability Advisory Panel established**
442 **pursuant to § 32.1-276.12 of the Code of Virginia, as created by this act shall submit a report, in**
443 **collaboration with the State Corporation Commission's Bureau of Insurance and the Office of the**
444 **Attorney General, to the Governor, the Chairs of the Senate Committees on Commerce and Labor and**
445 **Education and Health, and the Chairs of the House Committees on Labor and Commerce and Health**
446 **and Human Services that includes the legal implications of, operational recommendations for, evidence**
447 **of effectiveness of, and any other relevant information related to the provisions of § 54.1-3431.1 of the**
448 **Code of Virginia, as created by this act.**