State PBM Reform Inventory

Updated October 2026

West Virginia

Issue	Summary	Citation
Licensing/Registration	A PBM must obtain a license from the Insurance Commissioner to operate in the state. A PBM must apply using an application form developed by the commissioner and pay an initial application fee or a renewal fee determined by the commissioner. Initial application and renewal fees may not exceed $10,000. Licenses are valid for 2 years and must be renewed by October 1 of even years. If a PBM only serves self-funding employee benefit plans governed by ERISA, the PBM does not have to obtain a license. However, they do have to register as a third-party administrator.	W. Va. Code § 33-51-8
Reporting Requirements	Any methodologies utilized by a PBM in connection with reimbursement shall be filed with the commissioner at the time of initial licensure and at any time thereafter that the methodology is changed by the PBM for use in determining MAC appeals. A PBM shall report to the commissioner on an annual basis, or more often as the commissioner deems necessary, for each health plan or covered entity the following information: • The aggregate amount of rebates received by the PBM; • The aggregate amount of rebates distributed to each health plan or covered entity contracted with the PBM; • The aggregate amount of rebates passed on to the enrollees of each health plan or covered entity at the point of sale that reduced the enrollees applicable deductible, copayment, coinsurance, or other cost-sharing amount; • The individual and aggregate amount paid by the health plan or covered entity to the PBM for pharmacist services itemized by pharmacy, by product, and by goods and services; and	W. Va. Code § 33-51-9; W. Va. Code §33-51-12

	• The individual and aggregate amount a PBM paid for pharmacist services itemized by pharmacy, by product, and by goods and services. A PBM shall annually report in the aggregate to the commissioner and to a health plan or covered entity the difference between the amount the PBM reimbursed a pharmacy and the amount the PBM charged a health plan. A health benefit plan or covered entity shall annually report to the commissioner the aggregate amount of credits, rebates, discounts, or other such payments received by the health benefit plan or covered entity from a PBM or drug manufacturer and disclose whether or not those credits, rebates, discounts or other such payments were passed on to reduce insurance premiums or rates. A PBM shall produce a quarterly report to the commissioner of all drugs appearing on the national average drug acquisition cost list reimbursed at least 10% below the national average drug acquisition cost, as well as all drugs reimbursed at least 10% above the national average drug acquisition cost. For each drug in the report, a PBM shall include the month the drug was dispensed, the quantity of the drug dispensed, the amount the pharmacy was reimbursed, whether the dispensing pharmacy was an affiliate of the PBM, whether the drug was dispensed pursuant to a government health plan, and the average national drug acquisition cost for the month the drug was dispensed. This report shall exclude 340B drugs. A PBM is required to report to the agency the following, at least quarterly; • The overall total amount charged to the agency for all claims processed by the PBM • Overall total amount of reimbursements paid to pharmacy providers • Total number of claims where the PBM reimbursed a pharmacy provider less than the amount charged to the agency	

	• Amount paid to the pharmacy provider per claim including total cost of drug reimbursement, dispensing fees, copayments, etc.	
PBM Income	**Spread Pricing:** A PBM shall charge a health benefit plan administered by or on behalf of the state or a political subdivision of the state, the same price for a prescription drug as it pays a pharmacy for the prescription drug. A PBM shall offer a health plan the option of charging the plan the same price for a prescription drug as it pays a pharmacy for the prescription drug. **Rebate Pass-Through:** A covered individual's defined cost-sharing for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to at least 100% of all rebates received, or to be received, in connection with the dispensing or administration of the prescription drug. Any rebate over and above the defined cost-sharing would then be passed on to the health plan to reduce premiums. Nothing precludes an insurer from decreasing a covered individual's defined cost-sharing by an amount greater than what is previously stated. **Cost Containment (Medicaid):** • A PBM may not reimburse a pharmacy/pharmacist for a drug or service in an amount less than the amount the PBM reimburses itself or an affiliate for the same drug or service. • By July 1, 2026, the Medicaid program shall establish a pilot program to implement a pharmacy cost containment vendor. The vendor shall be separate and distinct from any PBM.	W. Va. Code § 33-51-9
Pharmacy Contracting	**Minimum Reimbursement:** A PBM may not reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the NADAC for the prescription drug or pharmacy service at the time the drug is administered or dispensed, plus a professional dispensing fee of $10.49.	W. Va. Code § 33-51-9; W. Va. Code §33-51-11

	If the national average drug acquisition cost is not available at the time a drug is administered or dispensed, a PBM may not be reimbursed in an amount that is less than the wholesale acquisition cost of the drug plus a professional dispensing fee of $10.49. A PBM may not discriminate in reimbursement or exclude a pharmacy from the PBM's network on the basis the pharmacy is a 340B entity. A PBM may not base pharmacy reimbursement for a drug on patient outcomes, scores, or metrics **Patient Steering:** A PBM may not reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the amount the PBM reimburses itself or an affiliate for the same prescription drug or pharmacy service. A 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 health benefit plan according to the terms offered by the health benefit plan; • 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 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. Monetary advantage or penalty includes higher copayment, a reduction in reimbursement for services, or promotion of one participating pharmacy over another by these methods; • 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; • Prohibit or otherwise limit a beneficiary's access to prescription drugs from a pharmacy or pharmacist enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage area by unreasonably designating the covered prescription drug as a specialty drug; • 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 are 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. • Limit a pharmacist, pharmacy, or pharmacy technician from providing a covered individual with information related to lower cost alternatives and cost share • Penalize a pharmacist, pharmacy, or pharmacy technician from discussing lower cost options including paying without a policy • Collect a cost share charged to cover individual that exceeds the total submitted charges to the PBM • Reimburse a 340B entity at a rate lower than that paid for the same drug in non-340B pharmacies • Place additional requirements, restrictions or burdens upon 340B entities that increase cost or administrative burden • Discriminate against a 340B entity in a manner that interferes with patient choice	
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A PBM may not collect from a pharmacy, a pharmacist, or a pharmacy technician a cost share charged to a covered	W. Va. Code § 33-51-9;

	individual that exceeds the total submitted charges by the pharmacy or pharmacist to the PBM. Cost sharing for each drug shall be calculated at the point of sale based on a price that includes all rebates received. **Copay Adjustment Programs:** When calculating an insured's contribution to any applicable cost-sharing requirement, a PBM shall include any cost-sharing amounts paid by the insured or on behalf of the insured by another person. For high-deductible health plans, this requirement shall only apply after a covered individual meets their minimum deductible to remain eligible for an HSA. **Copay Cap:** This requirement only applies to West Virginia public employee plans. A policy, plan, or contract that is issued or renewed on or after January 1, 2024, shall provide coverage for prescription insulin drugs and equipment. Cost sharing for a 30-day supply of a covered prescription insulin drug may not exceed $35 in aggregate, including situations where the covered person is prescribed more than one insulin drug, per 30-day supply, regardless of the amount or type of insulin needed to fill such covered person's prescription. Cost sharing for a 30-day supply of covered device(s) may not exceed $100 in aggregate, including situations where the covered person is prescribed more than one device, per 30-day supply. Each cost-share maximum is covered regardless of the person's deductible, copayment, coinsurance, or any other cost-sharing requirement.	W. Va. Code §33-15-4t; W. Va. Code §5-16-7g