CARDINAL INSTITUTE
FOR WEST VIRGINIA POLICY

WHEN REGULATION REPLACES MARKETS:
LESSONS FROM WEST VIRGINIA'S PBM EXPERIMENT

West Virginia's recent legislative actions represent a departure from free-market principles—compounding prior regulatory distortion with an additional layer of government control. Senate Bill 453 (2024) included new healthcare regulations, particularly involving pharmacy benefit managers (PBMs), and required a Business Intelligence Study to assess their impact.

While positioned to improve transparency and fairness, the legislation expanded the government's reach and altered reimbursement structures in ways that may unintentionally impede patient access, especially in a system already tangled up in red tape. The study completed at the end of 2024 found:

- Overall reimbursement rose slightly, but generic reimbursement fell by more than 50% under the NADAC-based formula.
- No spread pricing was detected, and observed differences in payment across pharmacies were driven by drug mix and prescription volume rather than rate discrimination.
- At the same time, the study identified 340B exclusions as a major contributor to higher net costs for PEIA, an issue left unaddressed by Senate Bill 453.

Instead of addressing the root causes of healthcare inefficiency (e.g., federal mandates, opaque reimbursement systems, and restricted market competition), West Virginia has furthered the regulatory complexity that drives up costs and constrains innovation in healthcare. Failures in other states illustrate the risks of this approach. For instance, in places where policymakers attempted aggressive, top-down regulation such as Arkansas and Louisiana, consequences included higher costs, fewer access points, and legal challenges. Such incidents highlight how well-intended actions can produce adverse effects that instead worsen the market.

West Virginia should pursue policies that simplify healthcare regulation, expand competition, and strengthen patient choice and outcomes.

Introduction

West Virginia's reputation as pro-growth and business-friendly has helped attract new industries and sustain newfound economic momentum. Over the past decade, tax cuts, school choice, and regulatory reform have made the state increasingly competitive in the greater Appalachian region.

But some changes in West Virginia's health policy indicate a departure from this trajectory. Rather than addressing problems at their source, policy responses have become counterproductive: worsening problems via more government intervention. Here's how.

1 West Virginia Legislature. "Senate Bill 453 (2024 Regular Session)." West Virginia Legislature, 2024.

The 2024 legislation imposed new detailed pricing and reporting mandates for PBMs contracting with the Public Employees Insurance Agency (PEIA), signaling a move toward greater state management of healthcare transactions.[2] Although goals of transparency and fairness are well-intentioned, this policy replaces voluntary negotiation with politically determined rules. Indeed, similar attempts made by other states demonstrate that such an approach is unlikely to deliver the intended improvements and weaken the health market's function. Moreover, West Virginia's own analysis now raises questions about whether SB 453 is meeting its stated intent.

What is a Pharmacy Benefit Manager, or "PBM?"

Pharmacy Benefit Managers, colloquially known as "PBMs," are administrators hired by insurers, employers, or government plans that manage prescription drug benefits.[3] This activity includes [4]:

1. **Building pharmacy networks** – deciding which pharmacies are "in network" and what they are paid.
2. **Negotiate drug prices and rebates with manufacturers**.
3. **Decide which drugs are covered and at what tier** – this is called a "formulary," which controls costs and influences market share.
4. **Process claims** – when a prescription is filled, the PBM processes the payment for the insurer and pharmacy.

PBMs sit in the middle of a distorted market and can be seen as de facto "middlemen. [5]" This has led to a complex relationship between pharmacies, PBMs, manufacturers, and insurers: pharmacies believe reimbursements are too low, manufacturers say there are too many rebates, insurers say they help to control costs, and legislators and patients often don't understand the system. Because of these dynamics, laws are often aimed to "fix PBMs" without fully understanding what occurs upstream.

While some critique of PBMs may be valid, PBMs are the result of government policies that [6]:

1. Regulated drug coverage
2. Required third-party payment
3. Controlled reimbursement formulas
4. Created opaque rebate systems
5. Blocked direct contracting
6. Built benefit designs into federal law
7. Added layers of compliance and reporting

Therefore, insurers and employers felt so burdened by the system, they outsourced the work. In simple terms, PBMs can help navigate bureaucratic systems.

Senate Bill 453

Passage of Senate Bill 453 introduced several reforms to regulate PBM operations within the PEIA system[7]:

- PBMs must provide quarterly data to PEIA, including total amounts charged, reimbursements paid, dates of service, drug identification, and ingredient cost
- PBM contracts are no longer confidential and subject to the West Virginia Freedom of Information Act (FOIA)

2 Jackson Kelly PLLC, "West Virginia Health Law 2024 Legislative Update." Jackson Kelly PLLC Health Law Monitor, 29 May 2024.
3 Lo Sasso, Tony. "The Case of PBMs." Regulation, Winter 2024–2025, Cato Institute.
4 Lo Sasso, Tony. "The Case of PBMs." Regulation, Winter 2024–2025, Cato Institute.
5 Brannon, Ike. "The War on Middlemen." Regulation, Winter 2024–2025, Cato Institute.
6 Hammond, Jackson. Health Care for a Lame Duck. Paragon Health Institute, 2024.
7 Jackson Kelly PLLC, "West Virginia Health Law 2024 Legislative Update." Jackson Kelly PLLC Health Law Monitor, 29 May 2024.

- PBMs are prohibited from reimbursing at less than the National Average Drug Acquisition Cost (NADAC) and must pay a dispensing fee at least equal to the Medicaid fee schedule, which materially changed payment dynamics for generic drugs.
- PBMs must pay a dispensing fee at least equal to the fee paid by West Virginia Medicaid
- PBMs are prohibited from utilizing "spread pricing." In other words, profiting from the difference between the charge of the plan and what they pay the pharmacy.

Regulation Begets Regulation: More Government Control Won't Fix Healthcare Markets

Through Senate Bill 453, such requirements expand the state's role from regulator to price setter. Rather than allowing market participants to negotiate terms based on efficiency and value, government determines reimbursement formulas, reporting standards, and disclosure rules. The result is a case of regulatory layering: using new mandates to fix the consequences of old.

This cycle mirrors what has occurred in other states. Instead of removing policies that triggered the need for such intermediaries, policymakers decided to control them directly. These actions limit market competition, raise compliance costs, and increase barriers to entry. This means fewer options for consumers, higher employer premiums, and weaker incentives for cost control.

Lessons from Arkansas and Louisiana

In Arkansas, Act 624 (2025) attempted to close all PBM-owned retail and mail-order pharmacies by barring PBMs from owning and operating them. But the rule proved burdensome and threatened to eliminate distribution outlets (e.g., mail-order and specialty delivery services often relied on by rural residents, Medicare beneficiaries, and military families).[8] In addition, the law faced Commerce Clause challenges, and an Arkansas court held the legislation discriminated against out-of-state companies and imposed an excessive burden on interstate commerce.[9] There, the court issued a preliminary injunction, illustrating how sweeping regulatory interventions often generate instability rather than clarity.

Similarly, under House Bill 358, Louisiana proposed mandates that many pharmacies would have been unable to meet, reflecting a broader trend in which government (not consumers) decides winners and losers in the healthcare supply chain. Analysts warned of cost escalation, potential pharmacy closures and access disruptions and the bill failed to pass.[10]

These examples demonstrate a consistent pattern: when states attempt to regulate complex, federally shaped markets through top-down regulation of intermediaries, the outcome is rarely lower costs or improved access. More often, such policies shrink competition, eliminate market entrants, and create legal uncertainty, harming patients.

West Virginia's Business Intelligence Study reinforces these lessons: top-down regulation targeting intermediaries tends to shift costs or distort incentives rather than resolving the underlying drivers of high spending.

The Cost of Overregulation

Senate Bill 453 and its administrative rules impose significant administrative and financial obligations on PBMs operating in West Virginia. Requirements include licensure, financial guarantees of at least $1 million, fees up to $10,000, and detailed reporting obligations that substantially raise compliance costs.[11]

These mandates add considerable overhead to firms managing prescription benefits and have contributed to reimbursement volatility revealed in the Business Intelligence Study. Ultimately, such burden is passed on to consumers.

8 Arkansas Advocate. "Federal Judge Blocks Arkansas Restrictions on Pharmacy Benefit Managers." Arkansas Advocate, 28 July 2025, https://arkansasadvocate.com/2025/07/28/federal-judge-blocks-arkansas-restrictions-on-pharmacy-benefit-managers/.

9 Carnegie, Theresa C., and Samantha Hawkins. "Federal Court Blocks Arkansas PBM Ownership Law, Citing Constitutional Violations." Mintz Insights Center – Viewpoints, 6 Aug. 2025, https://www.mintz.com/insights-center/viewpoints/2146/2025-08-06-federal-court-blocks-arkansas-pbm-ownership-law-citing.4

10 Pelican Institute for Public Policy. "The Slippery Slope of Market Intervention: Why Louisiana Must Choose Economic Freedom." Pelican Institute, 2024, https://pelicanpolicy.org/legal-regulatory/the-slippery-slope-of-market-intervention-why-louisiana-must-choose-economic-freedom/.

11 West Virginia Offices of the Insurance Commissioner. Insurance Bulletin No. 22-08: Licensing Fees for PBM and PAE. 18 May 2022.

Transparency and Missteps

While transparency is a legitimate goal, misguided mandates produce counterproductive results. When proprietary contract terms and negotiated discounts become public, market participants adjust their behavior; they may raise prices to match competitors rather than lowering them.[12]

Likewise, by removing confidentiality protections from PBM contracts and requiring granular reporting, the state risks unintentionally encouraging less competitive pricing behavior.[13]

Transparency and pricing reforms should aim to empower consumers, not bureaucracies. The best form of transparency in any market is choice—when individuals and employers can compare plans, prices, and services and make informed decisions free of state intervention.

Senate Bill 453's Business Intelligence Study

In accordance with provisions written into the bill, a comprehensive business intelligence study and analysis of PBM services was completed at the end of 2024. The study found the following[14]:

- Overall reimbursement increased 2.57% per day of therapy
- Generic drug reimbursement per day dropped by 52.5%
- No spread pricing was detected
- Observed payment disparities were explained by drug mix and prescription volume, not discriminatory rate-setting
- 340B prescriptions, which do not generate rebates and are excluded from discount guarantees, are a major driver of higher net costs

These findings indicate that Senate Bill 453's shift to a rigid NADAC-based reimbursement system may have created unintended consequences and worsened broader trends such as generic price deflation, and pharmacy consolidation, while also not addressing 340B—one of the largest contributors to PEIA's net costs.

Harm to Rural Communities and Veterans

The consequences of misguided regulation can be especially harmful for rural communities and veterans.

West Virginia faces one of the highest rates of "pharmacy deserts"— i.e., nearly 30% of West Virginians live in an area lacking access to a pharmacy.[15] For those in these regions, mail-order and benefit management can be valuable mechanisms of healthcare delivery. Policies that mandate rigid reimbursement floors, outright close pharmacies like Arkansas and Louisiana, or impose burdensome operational requirements risk weakening these systems and widening the state's pharmacy desert problem.

The Business Intelligence Study findings suggest that any reduction in generic reimbursement disproportionately affects independent pharmacies serving rural communities, amplifying access concerns in already-underserved areas

For instance, the TRICARE program, which provides prescription benefits to veterans and military families, depends heavily on mail-order services. These services are coordinated through national PBM networks. Disruptions in other states due to regulation like West Virginia's have raised concerns about continuity of care for this population.[16]

12 Lo Sasso, Tony. "The Case of PBMs." Regulation, Winter 2024–2025, Cato Institute.
13 Hemphill, Thomas A. "The Troubles with PBMs." Regulation, Spring 2017.
14 West Virginia Public Employees Insurance Agency. SB 453 Business Intelligence Study: Pharmacy Benefit Manager Services. PEIA, Dec. 2024.
15 U.S. Pharmacist. "The Impact of Pharmacy Deserts." U.S. Pharmacist, 2023.; West Virginia Rural Health Association. "Rural Communities Lose 10 Percent of Pharmacies in Two Decades." WVRHA, 2022.
16 Arkansas Advocate. "Federal Judge Blocks Arkansas Restrictions on Pharmacy Benefit Managers." Arkansas Advocate, 28 July 2025.

The Results of Senate Bill 453

The Business Intelligence Study conducted under Senate Bill 453 provides a clearer picture of how the law has reshaped West Virginia's pharmacy benefit landscape. Its findings point to several areas where the state's current approach may be misaligned with its stated goals of strengthening access and controlling costs. In particular, the Business Intelligence Study found that the NADAC-based reimbursement formula reduced generic reimbursement by more than 50%, a change that may have imposed significant pressure on independent pharmacies—especially those serving rural areas—without delivering measurable savings for PEIA. At the same time, the study identified 340B exclusions as a major contributor to higher net costs, an issue Senate Bill 453 did not target, even though it represents one of the most significant contributors to PEIA's net costs.

Given these outcomes, policymakers evaluating the state's future pharmacy benefit strategy may wish to reassess the reimbursement model adopted in Senate Bill 453. A more flexible, market-responsive approach could better support sustainable access to medication while avoiding the abrupt reimbursement shifts that currently threaten independent pharmacy viability. The current procurement cycle for PBM services provides a natural opportunity to revisit these requirements, compare alternative pricing frameworks, and ensure that new arrangements reflect both economic evidence and patient needs.

In addition, PEIA may benefit from leveraging new strategies—such as reference-based pricing[17]—that bring transparency and predictability to costs without imposing rigid, one-size-fits-all mandates on pharmacy reimbursements. Aligning incentives among plans, pharmacies, and benefit administrators may ultimately prove more effective than price setting.

Finally, as the study notes, the role of 340B in shaping PEIA's net costs warrants continued monitoring and further analysis to ensure that the program's financial impact does not undermine efforts to improve affordability for state employees.

Conclusion

West Virginia's recent efforts to regulate pharmacy benefit management were motivated by concerns about transparency, fairness, and the sustainability of the state's healthcare system. Yet the evidence gathered since Senate Bill 453 took effect suggests that its core provisions may not be achieving their intended goals. For example, the mandated reimbursement formula produced a sharp reduction in generic drug payments, disproportionately affecting independent pharmacies that serve many rural communities. The largest source of financial pressure, 340B exclusions, remains outside the scope of the statute.

These results mirror a broader pattern as seen in other states: when policymakers attempt to correct complex, upstream distortions in the drug market by tightening rules on PBMs, the outcome is often additional disruption rather than meaningful savings or improved access. The challenge facing West Virginia is not how to better manage PBMs, but how to structure a healthcare environment where price signals, competition, and consumer choice play a larger role in determining value.

Recent events also highlight the pressures facing independent and regional pharmacies. Fruth Pharmacy's announcement that it will sell its pharmacy operations to Walgreens, while driven by many market factors, is consistent with economic pressures identified in the Business Intelligence Study—most notably the decrease in generic reimbursement. Although individual business decisions cannot be directly traced to a single policy change, these developments underscore the importance of reassessing whether current or future law aligns with sustainable access to pharmacy services across the state.[18]

As the state prepares for the next PBM procurement cycle, it has an opportunity to refine its approach. A shift toward simpler, more competitive purchasing strategies paired with a reassessment of rigid statutory mandates could support a more stable pharmacy network and a more predictable cost trajectory for PEIA.

17 Lo Sasso, Tony. "The Case of PBMs." Regulation, Winter 2024–2025, Cato Institute.

18 Hemphill, Thomas A. "The Troubles with PBMs." Regulation, Spring 2017.

West Virginia's long-standing commitment to market-oriented principles provides a strong foundation for such reforms. By grounding future decisions in evidence rather than assumption, the state can move closer to a system that promotes access, efficiency, and affordability for the patients it serves—especially for rural and underserved populations who depend most on stable access to pharmacy services.

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