
SENATE BILL 5601

State of Washington

66th Legislature

2019 Regular Session

By Senators Rolfes, Short, Keiser, Llias, Kuderer, Walsh, Hobbs, King, Warnick, Honeyford, and Conway

Read first time 01/24/19. Referred to Committee on Health & Long Term Care.

1 AN ACT Relating to health care benefit management; amending RCW
2 19.340.010, 48.02.120, 19.340.100, 19.340.020, 19.340.070,
3 19.340.080, 19.340.090, and 48.02.220; adding a new section to
4 chapter 42.56 RCW; adding a new chapter to Title 48 RCW; creating new
5 sections; recodifying RCW 19.340.010, 19.340.020, 19.340.040,
6 19.340.050, 19.340.060, 19.340.070, 19.340.080, 19.340.090,
7 19.340.100, and 19.340.110; repealing RCW 19.340.030 and 19.365.010;
8 and providing an effective date.

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

10 NEW SECTION. **Sec. 1.** The legislature finds that growth in
11 managed health care systems has shifted substantial authority over
12 health care decisions from providers and patients to health carriers
13 and benefit managers. Benefit managers acting as intermediaries
14 between carriers, health care providers, and patients exercise broad
15 discretion to affect health care services recommended and delivered
16 by providers and the health care choices of patients. Regularly,
17 these benefit managers are making care decisions on behalf of
18 carriers and their decision makers routinely live outside of
19 Washington and may not hold any Washington health care provider
20 license. Benefit managers do not function as carriers. Therefore, it

1 is in the best interest of the public to create a separate chapter
2 for benefit managers.

3 The legislature intends to protect and promote the health,
4 safety, and welfare of Washington residents by establishing standards
5 for regulatory oversight of benefit managers.

6 **Sec. 2.** RCW 19.340.010 and 2016 c 210 s 3 are each amended to
7 read as follows:

8 The definitions in this section apply throughout this chapter
9 unless the context clearly requires otherwise.

10 (1) "Certification" has the same meaning as in RCW 48.43.005.

11 (2) "Claim" means a request from a pharmacy or pharmacist to be
12 reimbursed for the cost of filling or refilling a prescription for a
13 drug or for providing a medical supply or service.

14 ~~((2) "Commissioner" means the insurance commissioner established~~
15 ~~in chapter 48.02 RCW.))~~

16 (3) "Concurrent review" has the same meaning as in RCW 48.43.005.

17 (4) "Health care benefit manager" means any person or entity
18 providing service to, or acting on behalf of, a health carrier, a
19 public employee benefit program, or a school employee benefit
20 program, including a pharmacy benefit manager or a radiology benefit
21 manager, that directly or indirectly impacts the determination or
22 utilization of benefits for, or patient access to, health care
23 services, drugs, and supplies including, but not limited to:

24 (a) Prior authorization or preauthorization of benefits or care;

25 (b) Certification of benefits or care;

26 (c) Medical necessity determinations;

27 (d) Utilization review;

28 (e) Benefit determinations;

29 (f) Claims processing and repricing;

30 (g) Provider credentialing and recredentialing;

31 (h) Dispute resolution, grievances, or appeals relating to
32 determinations; and

33 (i) Provider network management.

34 (5) "Health care provider" or "provider" has the same meaning as
35 in RCW 48.43.005.

36 (6) "Health care service" has the same meaning as in RCW
37 48.43.005.

38 (7) "Health carrier" or "carrier" has the same meaning as in RCW
39 48.43.005.

1 (8) "Insurer" has the same meaning as in RCW 48.01.050.

2 ~~((4))~~ (9) "Network" means the group of participating providers,
3 pharmacies, and suppliers providing health care services, drugs, or
4 supplies to beneficiaries of a particular carrier or program benefit
5 plan.

6 (10) "Person" includes, as applicable, natural persons, licensed
7 health care providers, carriers, corporations, companies, trusts,
8 unincorporated associations, and partnerships.

9 (11) "Pharmacist" has the same meaning as in RCW 18.64.011.

10 ~~((5))~~ (12) "Pharmacy" has the same meaning as in RCW 18.64.011.

11 ~~((6))~~ (13)(a) "Pharmacy benefit manager" means a person ~~((that~~
12 ~~contracts with pharmacies on behalf of an insurer, a third-party~~
13 ~~payer, or the prescription drug purchasing consortium established~~
14 ~~under RCW 70.14.060 to))~~ providing service to, or acting on behalf
15 of, a health carrier, a public employee benefit program, or a school
16 employee benefit program, that directly or indirectly impacts the
17 determination or utilization of benefits for, or patient access to,
18 pharmacy benefits including but not limited to:

19 (i) ~~((Process))~~ Processing claims for prescription drugs or
20 medical supplies or ~~((provide))~~ providing retail network management
21 for pharmacies or pharmacists;

22 (ii) ~~((Pay))~~ Payment or payment authorization to pharmacies or
23 pharmacists for prescription drugs or medical supplies; or

24 (iii) ~~((Negotiate))~~ Negotiation of rebates with manufacturers for
25 drugs paid for or procured ~~((as described in this subsection))~~
26 directly or indirectly on behalf of a health carrier or a state
27 agency.

28 (b) "Pharmacy benefit manager" does not include a health care
29 service contractor as defined in RCW 48.44.010, a health maintenance
30 organization as defined in RCW 48.46.020, or an issuer as defined in
31 RCW 48.01.053.

32 ~~((7))~~ (14)(a) "Radiology benefit manager" means any person or
33 entity providing service to, or acting on behalf of, a health
34 carrier, a public employee benefit program, or a school employee
35 benefit program, that directly or indirectly impacts the
36 determination or utilization of benefits for, or patient access to,
37 the services of a licensed radiologist or to advanced diagnostic
38 imaging services including but not limited to:

1 (i) Processing claims for services and procedures performed by a
2 licensed radiologist or advanced diagnostic imaging service provider;
3 or

4 (ii) Payment or payment authorization to radiology clinics,
5 radiologists, or advanced diagnostic imaging service providers for
6 services or procedures.

7 (b) "Radiology benefit manager" does not include a health care
8 service contractor as defined in RCW 48.44.010, a health maintenance
9 organization as defined in RCW 48.46.020, or an issuer as defined in
10 RCW 48.01.053.

11 (15) "Third-party payor" means a person licensed under RCW
12 48.39.005.

13 (16) "Utilization review" has the same meaning as in RCW
14 48.43.005.

15 NEW SECTION. Sec. 3. (1) A person may not act in the capacity
16 of a health care benefit manager with respect to benefits for
17 Washington residents, unless that person obtains and maintains a
18 license issued by the commissioner.

19 (2) To obtain a license, a health care benefit manager must:

20 (a) Submit an application on forms and in a manner prescribed by
21 the commissioner and verified by the applicant by affidavit, or
22 certificate under RCW 9A.72.085. Applications must contain at least
23 the following information:

24 (i) The identity of the health care benefit manager and of
25 persons with any ownership or controlling interest in the applicant
26 including relevant business licenses and tax identification numbers,
27 and the identity of any entity that the health care benefit manager
28 has a controlling interest in;

29 (ii) The business name, address, phone number, and contact person
30 for the manager;

31 (iii) Whether the person does business as a pharmacy benefit
32 manager, a radiology benefit manager, a health care benefit manager
33 other than a pharmacy benefit manager or radiology benefit manager,
34 or a combination of different types of health care benefit managers;
35 and

36 (iv) Any other information as the commissioner may reasonably
37 require.

38 (b) Pay an initial license fee and annual renewal license fee
39 established in rule by the commissioner for each license. The fees

1 for each license must be set by the commissioner in an amount that
2 ensures the licensing, renewal, and oversight activities are self-
3 supporting. If one licensee has a contract with more than one
4 carrier, the licensee shall complete only one application providing
5 the detail necessary for each contract.

6 (3) All receipts from fees collected by the commissioner under
7 this section must be deposited into the commissioner's regulatory
8 account created in RCW 48.02.190.

9 (4) Before approving an application for or renewal of a license,
10 the commissioner must find that the health care benefit manager:

11 (a) Has not committed any act that resulted in denial,
12 suspension, or revocation of a license;

13 (b) Has paid the required fees; and

14 (c) Has the capacity to comply with and has designated a person
15 responsible for compliance with state and federal laws.

16 (5) Any material change in information provided to obtain or
17 renew a license must be filed with the commissioner within fifteen
18 days of the change.

19 (6) Every licensee shall retain a record of all transactions
20 completed under the license for a period of not less than seven years
21 from the date of their creation. All such records as to any
22 particular transaction must be kept available and open to inspection
23 by the commissioner during the seven years after the date of
24 completion of such transaction.

25 NEW SECTION. **Sec. 4.** (1) A licensee must file with the
26 commissioner in the form and manner prescribed by the commissioner,
27 every benefit management contract and contract amendment, and every
28 contract and contract amendment between the licensee and any other
29 person entered into directly or indirectly in support of such
30 licensee contract, at least thirty days prior to use of the contract
31 or amendment.

32 (2) Licensee contracts must be available for public inspection
33 and posted on the commissioner's web site. Contract compensation
34 provisions filed with the commissioner are confidential and are not
35 subject to public disclosure under RCW 48.02.120(2) or chapter 42.56
36 RCW, if filed in accordance with commissioner procedures for
37 submitting confidential filings, except for contract compensation
38 provisions that a reasonable person would believe encourages managers

1 to deny, delay, or limit benefits, and the method or formula for
2 compensation.

3 NEW SECTION. **Sec. 5.** (1) A licensee has a fiduciary duty to
4 patients and beneficiaries to perform services in accordance with
5 state and federal law.

6 (2) A licensee may not penalize, require, or provide financial
7 incentives including variations in premiums, deductibles, copayments,
8 or coinsurance, to beneficiaries as an incentive to use a specific
9 provider or a retail, mail order, or other network pharmacy, in which
10 a carrier, program, or a benefit manager has an ownership interest,
11 except for and only to the limited extent the commissioner adopts by
12 rule an exception for use of the financial incentive as necessary to
13 the operation of a health care benefit plan or program such as a
14 staff model health maintenance organization that depends upon patient
15 use of owned facilities.

16 (3) A licensee may not deny a benefit or impose a cost or
17 limitation upon a beneficiary of any health insurance policy, plan,
18 or contract providing benefits for health care services, drugs, or
19 supplies and no person may collect or attempt to collect a debt for
20 the delivery of health care services, drugs, or supplies from a
21 patient if such denial, limitation, cost, or debt is attributable to
22 a violation of this chapter or rules adopted under this chapter.

23 (4) For purposes of authorization for services, whether prior,
24 concurrent, or postservice, a medical necessity determination made by
25 the primary care provider, or portal of entry provider, is sufficient
26 for access to the initial six visits of care under RCW 48.43.016 and
27 may not require additional referrals or medical necessity
28 determinations by the licensee or carrier.

29 **Sec. 6.** RCW 48.02.120 and 2011 c 312 s 1 are each amended to
30 read as follows:

31 (1) The commissioner shall preserve in permanent form records of
32 his or her proceedings, hearings, investigations, and examinations,
33 and shall file such records in his or her office.

34 (2) The records of the commissioner and insurance filings in his
35 or her office shall be open to public inspection, except as otherwise
36 provided by section 4 of this act and this code.

37 (3) Except as provided in subsection (4) of this section,
38 actuarial formulas, statistics, and assumptions submitted in support

1 of a rate or form filing by an insurer, health care service
2 contractor, or health maintenance organization or submitted to the
3 commissioner upon his or her request shall be withheld from public
4 inspection in order to preserve trade secrets or prevent unfair
5 competition.

6 (4) For individual and small group health benefit plan rate
7 filings submitted on or after July 1, 2011, subsection (3) of this
8 section applies only to the numeric values of each small group rating
9 factor used by a health carrier as authorized by RCW 48.21.045(3)(a),
10 48.44.023(3)(a), and 48.46.066(3)(a). Subsection (3) of this section
11 may continue to apply for a period of one year from the date a new
12 individual or small group product filing is submitted or until the
13 next rate filing for the product, whichever occurs earlier, if the
14 commissioner determines that the proposed rate filing is for a new
15 product that is distinct and unique from any of the carrier's
16 currently or previously offered health benefit plans. Carriers must
17 make a written request for a product classification as a new product
18 under this subsection and must receive subsequent written approval by
19 the commissioner for this subsection to apply.

20 (5) Unless the commissioner has determined that a filing is for a
21 new product pursuant to subsection (4) of this section, for all
22 individual or small group health benefit rate filings submitted on or
23 after July 1, 2011, the health carrier must submit part I rate
24 increase summary and part II written explanation of the rate increase
25 as set forth by the department of health and human services at the
26 time of filing, and the commissioner must:

27 (a) Make each filing and the part I rate increase summary and
28 part II written explanation of the rate increase available for public
29 inspection on the tenth calendar day after the commissioner
30 determines that the rate filing is complete and accepts the filing
31 for review through the electronic rate and form filing system; and

32 (b) Prepare a standardized rate summary form, to explain his or
33 her findings after the rate review process is completed. The
34 commissioner's summary form must be included as part of the rate
35 filing documentation and available to the public electronically.

36 NEW SECTION. **Sec. 7.** A new section is added to chapter 42.56
37 RCW to read as follows:

38 Contract compensation provisions filed with the insurance
39 commissioner under section 4 of this act are exempt from disclosure

1 under this chapter if filed in accordance with commissioner
2 procedures for submitting confidential filings, except for contract
3 compensation provisions that a reasonable person would believe
4 encourages managers to deny, delay, or limit benefits, and the method
5 or formula for compensation.

6 **Sec. 8.** RCW 19.340.100 and 2016 c 210 s 4 are each amended to
7 read as follows:

8 (1) As used in this section:

9 (a) "Critical access pharmacy" means:

10 (i) A pharmacy in Washington that is outside a ten-mile radius of
11 any other pharmacy; or

12 (ii) A pharmacy in Washington that is within a ten-mile radius of
13 another pharmacy if closure of either pharmacy could result in
14 impaired access for a rural area, in which case both pharmacies must
15 be considered critical access pharmacies.

16 (b) "List" means the list of drugs for which predetermined
17 reimbursement costs have been established, such as a maximum
18 allowable cost or maximum allowable cost list or any other benchmark
19 prices utilized by ((the)) a health care benefit manager doing
20 business as a pharmacy benefit manager and must include the basis of
21 the methodology and sources utilized to determine multisource generic
22 drug reimbursement amounts.

23 ~~((b))~~ (c) "Multiple source drug" means a therapeutically
24 equivalent drug that is available from at least two manufacturers.

25 ~~((e))~~ (d) "Multisource generic drug" means any covered
26 outpatient prescription drug for which there is at least one other
27 drug product that is rated as therapeutically equivalent under the
28 food and drug administration's most recent publication of "Approved
29 Drug Products with Therapeutic Equivalence Evaluations;" is
30 pharmaceutically equivalent or bioequivalent, as determined by the
31 food and drug administration; and is sold or marketed in the state
32 during the period.

33 ~~((d))~~ (e) "Network pharmacy" means a retail drug outlet
34 licensed as a pharmacy under RCW 18.64.043 that contracts with a
35 health care benefit manager doing business as a pharmacy benefit
36 manager.

37 ~~((e))~~ (f) "Therapeutically equivalent" has the same meaning as
38 in RCW 69.41.110.

1 (2) A health care benefit manager doing business as a pharmacy
2 benefit manager:

3 (a) May not place a drug on a list unless there are at least two
4 therapeutically equivalent multiple source drugs, or at least one
5 generic drug available from only one manufacturer, generally
6 available for purchase by network pharmacies from national or
7 regional wholesalers;

8 (b) Shall ensure that all drugs on a list are readily available
9 for purchase by pharmacies in this state from national or regional
10 wholesalers that serve pharmacies in Washington;

11 (c) Shall ensure that all drugs on a list are not obsolete;

12 (d) Shall make available to each network pharmacy at the
13 beginning of the term of a contract, and upon renewal of a contract,
14 the sources utilized to determine the predetermined reimbursement
15 costs for multisource generic drugs of the health care benefit
16 manager doing business as a pharmacy benefit manager;

17 (e) Shall make a list available to a network pharmacy upon
18 request in a format that is readily accessible to and usable by the
19 network pharmacy;

20 (f) Shall update each list maintained by the health care benefit
21 manager doing business as a pharmacy benefit manager every seven
22 business days and make the updated lists, including all changes in
23 the price of drugs, available to network pharmacies in a readily
24 accessible and usable format;

25 (g) Shall ensure that dispensing fees are not included in the
26 calculation of the predetermined reimbursement costs for multisource
27 generic drugs;

28 (h) May not cause or knowingly permit the use of any
29 advertisement, promotion, solicitation, representation, proposal, or
30 offer that is untrue, deceptive, or misleading;

31 (i) May not charge a pharmacist or pharmacy a fee related to the
32 adjudication of a claim including, but not limited to, a fee for the
33 receipt and processing of a pharmacy claim, for the development or
34 management of claims processing services in a pharmacy benefit
35 manager network, or for participation in a pharmacy benefit manager
36 network;

37 (j) Unless approved by the pharmacy quality assurance commission,
38 may not require pharmacy accreditation standards or certification
39 requirements inconsistent with, more stringent than, or in addition
40 to requirements of the pharmacy quality assurance commission;

1 (k) May not reimburse a pharmacy or pharmacist in the state an
2 amount less than the amount the pharmacy benefit manager reimburses
3 an affiliate for providing the same pharmacist services; and

4 (l) May not retroactively deny or reduce a pharmacist for
5 services after adjudication of the claim, unless:

6 (i) The original claim was submitted fraudulently;

7 (ii) The original claim payment was incorrect because the
8 pharmacy or pharmacist had already been paid for the pharmacist's
9 services; or

10 (iii) The pharmacist services were not properly rendered by the
11 pharmacy or pharmacist.

12 (3) A health care benefit manager doing business as a pharmacy
13 benefit manager must establish a process by which a network pharmacy
14 may appeal its reimbursement for a drug subject to predetermined
15 reimbursement costs for multisource generic drugs. A network pharmacy
16 may appeal a predetermined reimbursement cost for a multisource
17 generic drug if the reimbursement for the drug is less than the net
18 amount that the network pharmacy paid to the supplier of the drug. An
19 appeal requested under this section must be completed within thirty
20 calendar days of the pharmacy submitting the appeal. If after thirty
21 days the network pharmacy has not received the decision on the appeal
22 from the health care benefit manager doing business as a pharmacy
23 benefit manager, then the appeal is considered denied.

24 The health care benefit manager doing business as a pharmacy
25 benefit manager shall uphold the appeal of a pharmacy with fewer than
26 fifteen retail outlets, within the state of Washington, under its
27 corporate umbrella if the pharmacy or pharmacist can demonstrate that
28 it is unable to purchase a therapeutically equivalent interchangeable
29 product from a supplier doing business in Washington at the health
30 care benefit manager doing business as a pharmacy benefit manager's
31 list price.

32 (4) A health care benefit manager doing business as a pharmacy
33 benefit manager must provide as part of the appeals process
34 established under subsection (3) of this section:

35 (a) A telephone number at which a network pharmacy may contact
36 the health care benefit manager doing business as a pharmacy benefit
37 manager and speak with an individual who is responsible for
38 processing appeals; and

39 (b) If the appeal is denied, the reason for the denial and the
40 national drug code of a drug that has been purchased by other network

1 pharmacies located in Washington at a price that is equal to or less
2 than the predetermined reimbursement cost for the multisource generic
3 drug. A pharmacy with fifteen or more retail outlets, within the
4 state of Washington, under its corporate umbrella may submit
5 information to the commissioner about an appeal under subsection (3)
6 of this section for purposes of information collection and analysis.

7 (5) (a) If an appeal is upheld under this section, the health care
8 benefit manager doing business as a pharmacy benefit manager shall
9 make a reasonable adjustment on a date no later than one day after
10 the date of determination.

11 (b) If the request for an adjustment has come from a critical
12 access pharmacy, (~~as defined by the state health care authority by~~
13 ~~rule for purposes related to the prescription drug purchasing~~
14 ~~consortium established under RCW 70.14.060,~~) the adjustment approved
15 under (a) of this subsection shall apply only to critical access
16 pharmacies.

17 (6) Beginning July 1, 2017, if a network pharmacy appeal to the
18 health care benefit manager doing business as a pharmacy benefit
19 manager is denied, or if the network pharmacy is unsatisfied with the
20 outcome of the appeal, the pharmacy or pharmacist may dispute the
21 decision and request review by the commissioner within thirty
22 calendar days of receiving the decision.

23 (a) All relevant information from the parties may be presented to
24 the commissioner, and the commissioner may enter an order directing
25 the health care benefit manager doing business as a pharmacy benefit
26 manager to make an adjustment to the disputed claim, deny the
27 pharmacy appeal, or take other actions deemed fair and equitable. An
28 appeal requested under this section must be completed within thirty
29 calendar days of the request.

30 (b) Upon resolution of the dispute, the commissioner shall
31 provide a copy of the decision to both parties within seven calendar
32 days.

33 (c) The commissioner may authorize the office of administrative
34 hearings, as provided in chapter 34.12 RCW, to conduct appeals under
35 this subsection (6).

36 (d) A health care benefit manager doing business as a pharmacy
37 benefit manager may not retaliate against a pharmacy for pursuing an
38 appeal under this subsection (6).

1 (e) This subsection (6) applies only to a pharmacy with fewer
2 than fifteen retail outlets, within the state of Washington, under
3 its corporate umbrella.

4 (7) This section does not apply to the state medical assistance
5 program.

6 ~~((8) A pharmacy benefit manager shall comply with any requests
7 for information from the commissioner for purposes of the study of
8 the pharmacy chain of supply conducted under section 7, chapter 210,
9 Laws of 2016.))~~

10 NEW SECTION. **Sec. 9.** Sections 3, 4, and 5 of this act
11 constitute a new chapter in Title 48 RCW.

12 NEW SECTION. **Sec. 10.** RCW 19.340.010, 19.340.020, and
13 19.340.040 through 19.340.110 are each recodified as sections in the
14 new chapter created in section 9 of this act.

15 **Sec. 11.** RCW 19.340.020 and 2014 c 213 s 3 are each amended to
16 read as follows:

17 As used in this section and RCW 19.340.040 through 19.340.090 (as
18 recodified by this act):

19 (1) "Audit" means an on-site or remote review of the records of a
20 pharmacy by or on behalf of an entity.

21 (2) "Clerical error" means a minor error:

22 (a) In the keeping, recording, or transcribing of records or
23 documents or in the handling of electronic or hard copies of
24 correspondence;

25 (b) That does not result in financial harm to an entity; and

26 (c) That does not involve dispensing an incorrect dose, amount,
27 or type of medication, or dispensing a prescription drug to the wrong
28 person.

29 (3) "Entity" includes:

30 (a) A health care benefit manager doing business as a pharmacy
31 benefit manager;

32 (b) An insurer;

33 (c) A third-party payor;

34 (d) A state agency; or

35 (e) A person that represents or is employed by one of the
36 entities described in this subsection.

1 (4) "Fraud" means knowingly and willfully executing or attempting
2 to execute a scheme, in connection with the delivery of or payment
3 for health care benefits, items, or services, that uses false or
4 misleading pretenses, representations, or promises to obtain any
5 money or property owned by or under the custody or control of any
6 person.

7 **Sec. 12.** RCW 19.340.070 and 2014 c 213 s 7 are each amended to
8 read as follows:

9 For purposes of RCW 19.340.020 and 19.340.040 through 19.340.090
10 (as recodified by this act), an entity, or an independent third party
11 that contracts with an entity to conduct audits, must allow as
12 evidence of validation of a claim:

13 (1) An electronic or physical copy of a valid prescription if the
14 prescribed drug was, within fourteen days of the dispensing date:

- 15 (a) Picked up by the patient or the patient's designee;
- 16 (b) Delivered by the pharmacy to the patient; or
- 17 (c) Sent by the pharmacy to the patient using the United States
18 postal service or other common carrier;

19 (2) Point of sale electronic register data showing purchase of
20 the prescribed drug, medical supply, or service by the patient or the
21 patient's designee; or

22 (3) Electronic records, including electronic beneficiary
23 signature logs, electronically scanned and stored patient records
24 maintained at or accessible to the audited pharmacy's central
25 operations, and any other reasonably clear and accurate electronic
26 documentation that corresponds to a claim.

27 **Sec. 13.** RCW 19.340.080 and 2014 c 213 s 8 are each amended to
28 read as follows:

29 (1)(a) After conducting an audit, an entity must provide the
30 pharmacy that is the subject of the audit with a preliminary report
31 of the audit. The preliminary report must be received by the pharmacy
32 no later than forty-five days after the date on which the audit was
33 completed and must be sent:

- 34 (i) By mail or common carrier with a return receipt requested; or
- 35 (ii) Electronically with electronic receipt confirmation.

36 (b) An entity shall provide a pharmacy receiving a preliminary
37 report under this subsection no fewer than forty-five days after
38 receiving the report to contest the report or any findings in the

1 report in accordance with the appeals procedure established under RCW
2 19.340.040(1) (as recodified by this act) and ~~((to provide))~~ must
3 allow the submission of additional documentation in support of the
4 claim. The entity shall consider a reasonable request for an
5 extension of time to submit documentation to contest the report or
6 any findings in the report.

7 (2) If an audit results in the dispute or denial of a claim, the
8 entity conducting the audit shall allow the pharmacy to resubmit the
9 claim using any commercially reasonable method, including facsimile,
10 mail, or ~~((electronic mail))~~ email.

11 (3) An entity must provide a pharmacy that is the subject of an
12 audit with a final report of the audit no later than sixty days after
13 the later of the date the preliminary report was received or the date
14 the pharmacy contested the report using the appeals procedure
15 established under RCW 19.340.040(1) (as recodified by this act). The
16 final report must include a final accounting of all moneys to be
17 recovered by the entity.

18 (4) Recoupment of disputed funds from a pharmacy by an entity or
19 repayment of funds to an entity by a pharmacy, unless otherwise
20 agreed to by the entity and the pharmacy, shall occur after the audit
21 and the appeals procedure established under RCW 19.340.040(1) (as
22 recodified by this act) are final. If the identified discrepancy for
23 an individual audit exceeds forty thousand dollars, any future
24 payments to the pharmacy may be withheld by the entity until the
25 audit and the appeals procedure established under RCW 19.340.040(1)
26 (as recodified by this act) are final.

27 **Sec. 14.** RCW 19.340.090 and 2014 c 213 s 9 are each amended to
28 read as follows:

29 RCW 19.340.020 and 19.340.040 through 19.340.090 (as recodified
30 by this act) do not:

31 (1) Preclude an entity from instituting an action for fraud
32 against a pharmacy;

33 (2) Apply to an audit of pharmacy records when fraud or other
34 intentional and willful misrepresentation is indicated by physical
35 review, review of claims data or statements, or other investigative
36 methods; or

37 (3) Apply to a state agency that is conducting audits or a person
38 that has contracted with a state agency to conduct audits of pharmacy

1 records for prescription drugs paid for by the state medical
2 assistance program.

3 **Sec. 15.** RCW 48.02.220 and 2016 c 210 s 5 are each amended to
4 read as follows:

5 (1) The commissioner shall accept (~~(registration)~~) licensing of
6 (~~(pharmacy)~~) health care benefit managers as established in (~~(RCW~~
7 ~~19.340.030)~~) section 3 of this act and receipts shall be deposited in
8 the insurance commissioner's regulatory account.

9 (2) The commissioner shall have enforcement authority over
10 chapter (~~(19.340)~~) 48.--- RCW (the new chapter created in section 9
11 of this act) consistent with requirements established in RCW
12 19.340.110 (as recodified by this act).

13 (3) The commissioner may adopt rules to implement chapter
14 (~~(19.340)~~) 48.--- RCW (the new chapter created in section 9 of this
15 act) and to establish (~~(registration)~~) licensing and renewal fees
16 that ensure the (~~(registration)~~) licensing, renewal, and oversight
17 activities are self-supporting.

18 NEW SECTION. **Sec. 16.** The following acts or parts of acts are
19 each repealed:

20 (1) RCW 19.340.030 (Pharmacy benefit managers—Registration—
21 Renewal) and 2016 c 210 s 1 & 2014 c 213 s 2; and

22 (2) RCW 19.365.010 (Registration required—Requirements) and 2015
23 c 166 s 1.

24 NEW SECTION. **Sec. 17.** The insurance commissioner shall adopt
25 any rules necessary to implement this act.

26 NEW SECTION. **Sec. 18.** Sections 1 through 16 of this act take
27 effect January 1, 2021.

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