E2SSB 5213 - H COMM AMD
By Committee on Health Care & Wellness

ADOPTED 02/29/2024

Strike everything after the enacting clause and insert the following:

"Sec. 1. RCW 48.200.020 and 2020 c 240 s 2 are each amended to read as follows:

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

(1) "Affiliate" or "affiliated employer" means a person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another specified person.

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

(3) "Employee benefits programs" means programs under both the public employees' benefits board established in RCW 41.05.055 and the school employees' benefits board established in RCW 41.05.740.

(4)(a) "Health care benefit manager" means a person or entity providing services to, or acting on behalf of, a health carrier or employee benefits programs, that directly or indirectly impacts the determination or utilization of benefits for, or patient access to, health care services, drugs, and supplies including, but not limited to:

(i) Prior authorization or preauthorization of benefits or care;

(ii) Certification of benefits or care;

(iii) Medical necessity determinations;

(iv) Utilization review;

(v) Benefit determinations;

(vi) Claims processing and repricing for services and procedures;

(vii) Outcome management;

(viii) ((~~Provider credentialing and recredentialing;~~

~~(ix)~~)) Payment or authorization of payment to providers and facilities for services or procedures;

((~~(x)~~)) (ix) Dispute resolution, grievances, or appeals relating to determinations or utilization of benefits;

((~~(xi)~~)) (x) Provider network management; or

((~~(xii)~~)) (xi) Disease management.

(b) "Health care benefit manager" includes, but is not limited to, health care benefit managers that specialize in specific types of health care benefit management such as pharmacy benefit managers, radiology benefit managers, laboratory benefit managers, and mental health benefit managers.

(c) "Health care benefit manager" does not include:

(i) Health care service contractors as defined in RCW 48.44.010;

(ii) Health maintenance organizations as defined in RCW 48.46.020;

(iii) Issuers as defined in RCW 48.01.053;

(iv) The public employees' benefits board established in RCW 41.05.055;

(v) The school employees' benefits board established in RCW 41.05.740;

(vi) Discount plans as defined in RCW 48.155.010;

(vii) Direct patient-provider primary care practices as defined in RCW 48.150.010;

(viii) An employer administering its employee benefit plan or the employee benefit plan of an affiliated employer under common management and control;

(ix) A union, either on its own or jointly with an employer, administering a benefit plan on behalf of its members;

(x) An insurance producer selling insurance or engaged in related activities within the scope of the producer's license;

(xi) A creditor acting on behalf of its debtors with respect to insurance, covering a debt between the creditor and its debtors;

(xii) A behavioral health administrative services organization or other county-managed entity that has been approved by the state health care authority to perform delegated functions on behalf of a carrier;

(xiii) A hospital licensed under chapter 70.41 RCW or ambulatory surgical facility licensed under chapter 70.230 RCW, to the extent that it performs provider credentialing or recredentialing, but no other functions of a health care benefit manager as described in subsection (4)(a) of this section;

(xiv) The Robert Bree collaborative under chapter 70.250 RCW;

(xv) The health technology clinical committee established under RCW 70.14.090; ((~~or~~))

(xvi) The prescription drug purchasing consortium established under RCW 70.14.060; or

(xvii) Any other entity that performs provider credentialing or recredentialing, but no other functions of a health care benefit manager as described in subsection (4)(a) of this section.

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

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

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

(8) "Laboratory benefit manager" means a person or entity providing service to, or acting on behalf of, a health carrier, employee benefits programs, or another entity under contract with a carrier, that directly or indirectly impacts the determination or utilization of benefits for, or patient access to, health care services, drugs, and supplies relating to the use of clinical laboratory services and includes any requirement for a health care provider to submit a notification of an order for such services.

(9) "Mental health benefit manager" means a person or entity providing service to, or acting on behalf of, a health carrier, employee benefits programs, or another entity under contract with a carrier, that directly or indirectly impacts the determination of utilization of benefits for, or patient access to, health care services, drugs, and supplies relating to the use of mental health services and includes any requirement for a health care provider to submit a notification of an order for such services.

(10) "Network" means the group of participating providers, pharmacies, and suppliers providing health care services, drugs, or supplies to beneficiaries of a particular carrier or plan.

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

(12)(a) "Pharmacy benefit manager" means a person that contracts with pharmacies on behalf of ((~~an insurer, a third-party payor, or the prescription drug purchasing consortium established under RCW 70.14.060~~)) a health carrier, employee benefits program, or medicaid managed care program to:

(i) Process claims for prescription drugs or medical supplies or provide retail network management for pharmacies or pharmacists;

(ii) Pay pharmacies or pharmacists for prescription drugs or medical supplies;

(iii) Negotiate rebates, discounts, or other price concessions with manufacturers for drugs paid for or procured as described in this subsection;

(iv) ((~~Manage~~)) Establish or manage pharmacy networks; or

(v) Make credentialing determinations.

(b) "Pharmacy benefit manager" does not include a health care service contractor as defined in RCW 48.44.010.

(13)(a) "Radiology benefit manager" means any person or entity providing service to, or acting on behalf of, a health carrier, employee benefits programs, or another entity under contract with a carrier, that directly or indirectly impacts the determination or utilization of benefits for, or patient access to, the services of a licensed radiologist or to advanced diagnostic imaging services including, but not limited to:

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

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

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

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

(15) "Covered person" has the same meaning as in RCW 48.43.005.

(16) "Mail order pharmacy" means a pharmacy that primarily dispenses prescription drugs to patients through the mail or common carrier.

(17) "Pharmacy network" means the pharmacies located in the state or licensed under chapter 18.64 RCW and contracted by a pharmacy benefit manager to dispense prescription drugs to covered persons.

Sec. 2. RCW 48.200.030 and 2020 c 240 s 3 are each amended to read as follows:

(1) To conduct business in this state, a health care benefit manager must register with the commissioner and annually renew the registration.

(2) To apply for registration with the commissioner under this section, a health care benefit manager must:

(a) Submit an application on forms and in a manner prescribed by the commissioner and verified by the applicant by affidavit or declaration under chapter 5.50 RCW. Applications must contain at least the following information:

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

(ii) The business name, address, phone number, and contact person for the health care benefit manager;

(iii) Any areas of specialty such as pharmacy benefit management, radiology benefit management, laboratory benefit management, mental health benefit management, or other specialty;

(iv) A copy of the health care benefit manager's certificate of registration with the Washington state secretary of state; and

((~~(iv)~~)) (v) Any other information as the commissioner may reasonably require.

(b) Pay an initial registration fee and annual renewal registration fee as established in rule by the commissioner. The fees for each registration must be set by the commissioner in an amount that ensures the registration, renewal, and oversight activities are self-supporting. If one health care benefit manager has a contract with more than one carrier, the health care benefit manager must complete only one application providing the details necessary for each contract.

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

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

(a) Has not committed any act that would result in denial, suspension, or revocation of a registration;

(b) Has paid the required fees; and

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

(5) Any material change in the information provided to obtain or renew a registration must be filed with the commissioner within thirty days of the change.

(6) Every registered health care benefit manager must retain a record of all transactions completed for a period of not less than seven years from the date of their creation. All such records as to any particular transaction must be kept available and open to inspection by the commissioner during the seven years after the date of completion of such transaction.

Sec. 3. RCW 48.200.050 and 2020 c 240 s 5 are each amended to read as follows:

(1) Upon notifying a carrier or health care benefit manager of an inquiry or complaint filed with the commissioner pertaining to the conduct of a health care benefit manager identified in the inquiry or complaint, the commissioner must provide notice of the inquiry or complaint ((~~concurrently~~)) to the health care benefit manager ((~~and~~)). Notice must also be sent to any carrier to which the inquiry or complaint pertains. The commissioner shall respond to and investigate complaints related to the conduct of a health care benefit manager subject to this chapter directly, without requiring that the complaint be pursued exclusively through a contracting carrier.

(2) Upon receipt of an inquiry from the commissioner, a health care benefit manager must provide to the commissioner within fifteen business days, in the form and manner required by the commissioner, a complete response to that inquiry including, but not limited to, providing a statement or testimony, producing its accounts, records, and files, responding to complaints, or responding to surveys and general requests. Failure to make a complete or timely response constitutes a violation of this chapter.

(3) Subject to chapter 48.04 RCW, if the commissioner finds that a health care benefit manager or any person responsible for the conduct of the health care benefit manager's affairs has:

(a) Violated any provision of this chapter or insurance law, or violated any rule, subpoena, or order of the commissioner or of another state's insurance commissioner;

(b) Failed to renew the health care benefit manager's registration;

(c) Failed to pay the registration or renewal fees;

(d) Provided incorrect, misleading, incomplete, or materially untrue information to the commissioner, to a carrier, or to a beneficiary;

(e) Used fraudulent, coercive, or dishonest practices, or demonstrated incompetence, or financial irresponsibility in this state or elsewhere; or

(f) Had a health care benefit manager registration, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;

the commissioner may take any combination of the following actions against a health care benefit manager or any person responsible for the conduct of the health care benefit manager's affairs, other than an employee benefits program:

(i) Place on probation, suspend, revoke, or refuse to issue or renew the health care benefit manager's registration;

(ii) Issue a cease and desist order against the health care benefit manager ((~~and~~)), contracting carrier, or both;

(iii) Fine the health care benefit manager up to five thousand dollars per violation, and the contracting carrier is subject to a fine for acts conducted under the contract;

(iv) Issue an order requiring corrective action against the health care benefit manager, the contracting carrier acting with the health care benefit manager, or both the health care benefit manager and the contracting carrier acting with the health care benefit manager; and

(v) Temporarily suspend the health care benefit manager's registration by an order served by mail or by personal service upon the health care benefit manager not less than three days prior to the suspension effective date. The order must contain a notice of revocation and include a finding that the public safety or welfare requires emergency action. A temporary suspension under this subsection (3)(f)(v) continues until proceedings for revocation are concluded.

(4) A stay of action is not available for actions the commissioner takes by cease and desist order, by order on hearing, or by temporary suspension.

(5)(a) Health carriers and employee benefits programs are responsible for the compliance of any person or organization acting directly or indirectly on behalf of or at the direction of the carrier or program, or acting pursuant to carrier or program standards or requirements concerning the coverage of, payment for, or provision of health care benefits, services, drugs, and supplies.

(b) A carrier or program contracting with a health care benefit manager is responsible for the health care benefit manager's violations of this chapter, including a health care benefit manager's failure to produce records requested or required by the commissioner.

(c) No carrier or program may offer as a defense to a violation of any provision of this chapter that the violation arose from the act or omission of a health care benefit manager, or other person acting on behalf of or at the direction of the carrier or program, rather than from the direct act or omission of the carrier or program.

Sec. 4. RCW 48.200.210 and 2020 c 240 s 10 are each amended to read as follows:

The definitions in this section apply throughout this section and RCW 48.200.220 through 48.200.290 unless the context clearly requires otherwise.

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

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

(3) "Clerical error" means a minor error:

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

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

(c) That does not involve dispensing an incorrect dose, amount, or type of medication, <u>failing to dispense a medication,</u> or dispensing a prescription drug to the wrong person.

(4) "Entity" includes:

(a) A pharmacy benefit manager;

(b) An insurer;

(c) A third-party payor;

(d) A state agency; or

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

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

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

(7) "Pharmacy" has the same meaning as in RCW 18.64.011.

(8) "Third-party payor" means a person licensed under RCW 48.39.005.

Sec. 5. RCW 48.200.280 and 2020 c 240 s 15 are each amended to read as follows:

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "List" means the list of drugs for which ((~~predetermined~~)) reimbursement costs have been established((~~, such as a maximum allowable cost or maximum allowable cost list or any other benchmark prices utilized by the pharmacy benefit manager and must include the basis of the methodology and sources utilized~~)) to determine ((~~multisource generic drug~~)) reimbursement amounts.

(b) "Multiple source drug" means ((~~a therapeutically equivalent drug that is available from at least two manufacturers~~)) any covered outpatient prescription drug for which there is at least one other drug product that is rated as therapeutically equivalent under the food and drug administration's most recent publication of "*Approved Drug Products with Therapeutic Equivalence Evaluations*"; is pharmaceutically equivalent or bioequivalent, as determined by the food and drug administration; and is sold or marketed in the state.

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

~~(d)~~)) "Network pharmacy" means a retail drug outlet licensed as a pharmacy under RCW 18.64.043 that contracts with a pharmacy benefit manager.

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

(2) A pharmacy benefit manager:

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

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

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

(d) Shall make available to each network pharmacy at the beginning of the term of a contract, and upon renewal of a contract, the sources utilized to determine the ((~~predetermined~~)) reimbursement costs for ((~~multisource generic~~)) multiple source drugs of the pharmacy benefit manager;

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

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

(g) Shall ensure that dispensing fees are not included in the calculation of the ((~~predetermined~~)) reimbursement costs for ((~~multisource generic~~)) multiple source drugs;

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

(i) May not charge a pharmacy a fee related to the adjudication of a claim, credentialing, participation, certification, accreditation, or enrollment in a network including, but not limited to, a fee for the receipt and processing of a pharmacy claim, for the development or management of claims processing services in a pharmacy benefit manager network, or for participating in a pharmacy benefit manager network, and may not condition or link restrictions on fees

related to credentialing, participation, certification, or enrollment in a pharmacy benefit manager's pharmacy network with a pharmacy's inclusion in the pharmacy benefit manager's pharmacy network for other lines of business;

(j) May not require accreditation standards inconsistent with or more stringent than accreditation standards established by a national accreditation organization;

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

(l) May not directly or indirectly retroactively deny or reduce a claim or aggregate of claims after the claim or aggregate of claims has been adjudicated, unless:

(i) The original claim was submitted fraudulently; or

(ii) The denial or reduction is the result of a pharmacy audit conducted in accordance with RCW 48.200.220; and

(m) May not exclude a pharmacy from their pharmacy network based solely on the pharmacy being newly opened or open less than a defined amount of time, or because a license or location transfer occurs, unless there is a pending investigation for fraud, waste, and abuse.

(3) A pharmacy benefit manager must establish a process by which a network pharmacy, or its representative, may appeal its reimbursement for a drug ((~~subject to predetermined reimbursement costs for multisource generic drugs~~)). A network pharmacy may appeal a ((~~predetermined reimbursement cost~~)) reimbursement amount paid by a pharmacy benefit manager for a ((~~multisource generic~~)) drug if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug. An appeal requested under this section must be completed within thirty calendar days of the pharmacy submitting the appeal. If after thirty days the network pharmacy has not received the decision on the appeal from the pharmacy benefit manager, then the appeal is considered denied.

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

(4) Before a pharmacy or pharmacist files an appeal pursuant to this section, upon request by a pharmacy or pharmacist, a pharmacy benefit manager must provide a current and accurate list of bank identification numbers, processor control numbers, and pharmacy group identifiers for health plans and self-funded group health plans that have opted in to sections 5, 7, and 8 of this act pursuant to section 9 of this act with which the pharmacy benefit manager either has a current contract or had a contract that has been terminated within the past 12 months to provide pharmacy benefit management services.

(5) A pharmacy benefit manager must provide as part of the appeals process established under subsection (3) of this section:

(a) A telephone number at which a network pharmacy may contact the pharmacy benefit manager and speak with an individual who is responsible for processing appeals; and

(b) If the appeal is denied, the reason for the denial and the national drug code of a drug that has been purchased by other network pharmacies located in Washington at a price that is equal to or less than the ((~~predetermined~~)) reimbursement ((~~cost~~)) amount paid by the pharmacy benefit manager for the ((~~multisource generic~~)) drug. A pharmacy with ((~~fifteen~~)) 15 or more retail outlets, within the state of Washington, under its corporate umbrella may submit information to the commissioner about an appeal under subsection (3) of this section for purposes of information collection and analysis.

((~~(5)~~)) (6)(a) If an appeal is upheld under this section, the pharmacy benefit manager shall make a reasonable adjustment on a date no later than one day after the date of determination.

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

((~~(6)~~)) (7) Beginning July 1, 2017, if a network pharmacy appeal to the pharmacy benefit manager is denied, or if the network pharmacy is unsatisfied with the outcome of the appeal, the pharmacy or pharmacist may dispute the decision and request review by the commissioner within thirty calendar days of receiving the decision.

(a) All relevant information from the parties may be presented to the commissioner, and the commissioner may enter an order directing the pharmacy benefit manager to make an adjustment to the disputed

claim, deny the pharmacy appeal, or take other actions deemed fair and equitable. An appeal requested under this section must be completed within thirty calendar days of the request.

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

(c) The commissioner may authorize the office of administrative hearings, as provided in chapter 34.12 RCW, to conduct appeals under this subsection ((~~(6)~~)) (7).

(d) A pharmacy benefit manager may not retaliate against a pharmacy for pursuing an appeal under this subsection ((~~(6)~~)) (7).

(e) This subsection ((~~(6)~~)) (7) applies only to a pharmacy with fewer than fifteen retail outlets, within the state of Washington, under its corporate umbrella.

((~~(7)~~)) (8) This section does not apply to the state medical assistance program.

NEW SECTION. **Sec. 6.** A new section is added to chapter 48.200 RCW to read as follows:

(1) Each health care benefit manager must appoint the commissioner as its attorney to receive service of, and upon whom must be served, all legal process issued against it in this state for causes of action arising within this state. Service upon the commissioner as attorney constitutes service upon the health care benefit manager. Service of legal process against the health care benefit manager can be had only by service upon the commissioner, except actions upon contractor bonds pursuant to RCW 18.27.040, where service may be upon the department of labor and industries.

(2) With the appointment the health care benefit manager must designate by name, email address, and address the person to whom the commissioner must forward legal process so served upon them. The health care benefit manager may change the person by filing a new designation.

(3) The health care benefit manager must keep the designation, address, and email address filed with the commissioner current.

(4) The appointment of the commissioner as attorney is irrevocable, binds any successor in interest or to the assets or liabilities of the health care benefit manager, and remains in effect as long as there is in force in this state any contract made by the

health care benefit manager or liabilities or duties arising therefrom.

(5) The service of process must be accomplished and processed in the manner prescribed under RCW 48.02.200.

NEW SECTION. **Sec. 7.** A new section is added to chapter 48.200 RCW to read as follows:

(1) A pharmacy benefit manager may not:

(a) Reimburse a network pharmacy an amount less than the contract price between the pharmacy benefit manager and the insurer, third-party payor, or the prescription drug purchasing consortium the pharmacy benefit manager has contracted with;

(b) Require a covered person to pay more at the point of sale for a covered prescription drug than is required under RCW 48.43.430; or

(c) Require or coerce a patient to use their owned or affiliated pharmacies.

(2) A pharmacy benefit manager shall:

(a) Apply the same utilization review, fees, days allowance, and other conditions upon a covered person when the covered person obtains a prescription drug from a pharmacy that is included in the pharmacy benefit manager's pharmacy network, including mail order pharmacies;

(b) Permit the covered person to receive delivery or mail order of a prescription drug through any network pharmacy that is not primarily engaged in dispensing prescription drugs to patients through the mail or common carrier; and

(c) For new prescriptions issued after the effective date of this section, receive affirmative authorization from a covered person before filling prescriptions through a mail order pharmacy.

(3) If a covered person is using a mail order pharmacy, the pharmacy benefit manager shall:

(a) Allow for dispensing at local network pharmacies under the following circumstances to ensure patient access to prescription drugs:

(i) If the prescription is delayed more than one day after the expected delivery date provided by the mail order pharmacy; or

(ii) If the prescription drug arrives in an unusable condition; and

(b) Ensure patients have easy and timely access to prescription counseling by a pharmacist.

NEW SECTION. **Sec. 8.** A new section is added to chapter 48.200 RCW to read as follows:

(1) A pharmacy benefit manager may not retaliate against a pharmacist or pharmacy for disclosing information in a court, in an administrative hearing, or legislative hearing, if the pharmacist or pharmacy has a good faith belief that the disclosed information is evidence of a violation of a state or federal law, rule, or regulation.

(2) A pharmacy benefit manager may not retaliate against a pharmacist or pharmacy for disclosing information to a government or law enforcement agency, if the pharmacist or pharmacy has a good faith belief that the disclosed information is evidence of a violation of a state or federal law, rule, or regulation.

(3) A pharmacist or pharmacy shall make reasonable efforts to limit the disclosure of confidential and proprietary information.

(4) Retaliatory actions against a pharmacy or pharmacist include cancellation of, restriction of, or refusal to renew or offer a contract to a pharmacy solely because the pharmacy or pharmacist has:

(a) Made disclosures of information that the pharmacist or pharmacy believes is evidence of a violation of a state or federal law, rule, or regulation;

(b) Filed complaints with the plan or pharmacy benefit manager; or

(c) Filed complaints against the plan or pharmacy benefit manager with the commissioner.

NEW SECTION. **Sec. 9.** A new section is added to chapter 48.200 RCW to read as follows:

(1) Nothing in this act expands or restricts the entities subject to this chapter. Therefore, except as provided in subsection (2) of this section, this chapter continues to be inapplicable to a person or entity providing services to, or acting on behalf of, a union or employer administering a self-funded group health plan governed by the provisions of the federal employee retirement income security act of 1974 (29 U.S.C. Sec. 1001 et seq.).

(2) Sections 5, 7, and 8 of this act apply to a pharmacy benefit manager's conduct pursuant to a contract with a self-funded group health plan governed by the provisions of the federal employee retirement income security act of 1974 (29 U.S.C. Sec. 1001 et seq.) only if the self-funded group health plan elects to participate in

sections 5, 7, and 8 of this act. To elect to participate in these provisions, a self-funded group health plan or its administrator shall provide notice, on a periodic basis, to the commissioner in a manner and by a date prescribed by the commissioner, attesting to the plan's participation and agreeing to be bound by sections 5, 7, and 8 of this act. A self-funded group health plan or its administrator that elects to participate under this section, and any pharmacy benefit manager it contracts with, shall comply with sections 5, 7, and 8 of this act.

(3) The commissioner does not have enforcement authority related to a pharmacy benefit manager's conduct pursuant to a contract with a self-funded group health plan governed by the federal employee retirement income security act of 1974, 29 U.S.C. Sec. 1001 et seq., that elects to participate in sections 5, 7, and 8 of this act.

Sec. 10. RCW 41.05.017 and 2022 c 236 s 3, 2022 c 228 s 2, and 2022 c 10 s 2 are each reenacted and amended to read as follows:

Each health plan that provides medical insurance offered under this chapter, including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, are subject to the provisions of RCW 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545, 48.43.550, 70.02.110, 70.02.900, 48.43.190, 48.43.083, 48.43.0128, 48.43.780, 48.43.435, 48.43.815, 48.200.020 through 48.200.280, sections 6 through 8 of this act, and chapter 48.49 RCW.

NEW SECTION. **Sec. 11.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 12.** Sections 5 and 7 through 9 of this act take effect January 1, 2026."

Correct the title.

EFFECT: Aligns the definition of "pharmacy benefit manager" (PBM) with the definition of "health care benefit manager" (HCBM) by changing the entities with whom the PBM contracts from "insurers, third-party payors, or the prescription drug consortium" to "health carriers, employee benefits programs, or Medicaid managed care programs." Clarifies that a union is exempt from the definition of

health care benefit manager (HCBM) when it administers a health benefit plan either on its own or jointly with an employer.

Modifies requirements relating to service of process by: (1) Allowing process relating to contractor bonds to be filed with the Department of Labor & Industries; (2) requiring the HCBM to designate the name and contact information for the person to whom the Insurance Commissioner (Commissioner) must forward the legal process; (3) requiring the HCBM to keep the designation current; (4) indicating that the appointment of the Commissioner as attorney is irrevocable; and (5) requiring the service to be accomplished and processed in the same manner as other insurance-related service.

Removes the prohibition against a PBM soliciting or incentivizing a patient to use the PBM's owned or affiliated pharmacies, and instead prohibits a PBM from requiring or coercing a patient to use the PBM's affiliated pharmacies.

Removes the requirement that a PBM apply the same cost-sharing amounts across its network pharmacies. Requires the PBM to apply the same utilization review across its network pharmacies.

Clarifies that the bill does not expand or restrict the entities subject to state laws relating to HCBMs. Specifies that state laws relating to HCBMs continue to be inapplicable to a person or entity providing services to, or acting on behalf of, a union or employer administering a self-funded group plan, unless the union or employer elects to participate in the state laws.

--- END ---