Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

E2SSB 5213

Brief Description: Concerning health care benefit managers.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Kuderer, Short, Cleveland, Conway, Dhingra, Rolfes, Wellman and Wilson, C.).

Brief Summary of Engrossed Second Substitute Bill

- Changes requirements relating to health care benefit managers.
- Changes requirements relating to pharmacy benefit managers.
- Allows federally regulated self-funded group plans to opt into state regulations on pharmacy benefit managers.

Hearing Date: 2/20/24

Staff: Jim Morishima (786-7191).

Background:

Health Care Benefit Managers.

Definition.
A health care benefit manager (HCBM) is a person or entity providing service to, or acting on behalf of, a health carrier, a public employee benefit program, or a school employee benefit program, that directly or indirectly impacts the determination or utilization of benefits for, or patient access to, health care services, drugs, and supplies. Tasks that may be performed by an HCBM include prior authorization and provider credentialing or recredentialing.

Several types of entities are excluded from the definition of HCBM, including hospitals or ambulatory surgical facilities.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Registration.
All health care benefit managers (HCBMS), including radiology benefit managers (RBM) and pharmacy benefit managers (PBMs) are required to register with the Insurance Commissioner (Commissioner). When registering, an HCBM must provide the following to the Commissioner:

- the identity of the HCBM and the individuals with a controlling interest in the HCBM, including the business name, address, phone number, and a contact person;
- the identity of any entity in which the HCBM has a controlling interest;
- whether the HCBM does business as a PBM, an RBM, a laboratory benefit manager, a mental health benefit manager, or a different type of benefit manager; and
- any other information reasonably required by the Commissioner.

Enforcement.
The Commissioner may take action against an HCBM or contracting health carrier for enumerated reasons including violations of any insurance law or any rule, subpoena, or order of the Commissioner. The Commissioner must provide notice of an inquiry or complaint against an HCBM concurrently to the HCBM and any carrier to which the inquiry or complaint pertains. The types of actions the Office of the Insurance Commissioner (OIC) may take against an HCBM include issuing a cease and desist order against the HCBM and contracting health carrier.

Pharmacy Benefit Managers.

Definition.
A PBM is a type of HCBM that performs a variety of pharmacy-related tasks on behalf of a health carrier, including negotiating rebates with manufacturers, and managing pharmacy networks.

Pharmacy Reimbursement.
A PBM may not place a drug on its list of drugs for which predetermined reimbursement costs have been established 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 in Washington. The PBM must make available the sources to determine the predetermined reimbursement costs for the multisource generic drugs of the PBM. Dispensing fees may not be included in the calculation of the predetermined reimbursement costs for multisource generic drugs.

Appeals Process.
A PBM must establish a process through which a network pharmacy may appeal reimbursements for drugs subject to predetermined reimbursement costs for multisource generic drugs. A PBM must uphold an appeal if a pharmacy with fewer than 15 retail outlets in Washington can demonstrate that it is unable to purchase a therapeutically equivalent interchangeable product from a supplier doing business in Washington at the PBM's price. If an appeal is upheld for a

pharmacy of any size, the PBM must make a reasonable adjustment. A pharmacy with fewer than 15 retail outlets in Washington may request a review of the PBM's decision by the Office of the Insurance Commissioner.

Prohibited Conduct.
A PBM may not:

- cause or knowingly permit to be used any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading;
- charge a pharmacist or pharmacy a fee related to the adjudication of a claim, credentialing, participation, certification, accreditation, or enrollment in a network, including a fee for the receipt and processing of a pharmacy claim, for the development or management of claims processing services in a PBM network, or for participating in a PBM network;
- require accreditation standards inconsistent with or more stringent than accreditation standards established by a national accreditation organization;
- reimburse a pharmacy or pharmacist an amount less than the amount the PBM reimburses an affiliate for providing the same services; or
- retroactively deny or reduce a claim or aggregate of claims after the claim or aggregate of claims has been adjudicated, unless the original claim was submitted fraudulently or the denial or reduction is the result of a pharmacy audit.

Pharmacy Audit Standards.
An entity that audits pharmacy claims is subject to certain minimum standards. For example, the entity may not recoup costs related to clerical errors. A clerical error is a minor error in the keeping, recording, or transcribing of records or documents, or in the handling of electronic or hard copies of correspondence, that:

- does not result in financial harm;
- does not involve dispensing an incorrect dose, amount, or type of medication; and
- does not involve dispensing a prescription drug to the wrong person.

Summary of Bill:

Health Care Benefit Managers.

Definition.
An entity, including a hospital, that performs provider credentialing or recredentialing is excluded from the definition of health care benefit manager (HCBM) only if it performs no other functions of an HCBM.

Registration.
When registering with the Office of the Insurance Commissioner (OIC), an HCBM must provide its certificate of registration with the Secretary of State.

Enforcement.
The requirement that notice of an inquiry or complaint must be sent concurrently to the HCBM

and the health carrier is eliminated. The OIC must respond to and investigate complaints related to the conduct of an HCBM directly, without requiring the complaint to be pursued exclusively through a contracting health carrier.

It is clarified that the OIC may take action on violations of laws relating to HCBMs and that cease and desist orders may be issued against an HCBM, a health carrier, or both (instead of against an HCBM and a health carrier).

Service of Process.
A registered HCBM must appoint the Insurance Commissioner (Commissioner) as its attorney to receive service, and upon whom service must be served, all legal process issued against it in Washington upon causes of action arising within Washington. Service upon the Commissioner as attorney constitutes service upon the HCBM.

Public and School Employee Health Plans.
State laws relating to HCBMs apply to health plans offered to state employees and school employees.

Pharmacy Benefit Managers.

Definition.
The types of tasks a pharmacy benefit manager (PBM) performs include negotiating discounts or other price concessions from manufacturers and establishing pharmacy networks.

Pharmacy Reimbursement.
Pharmacy reimbursement requirements are made generally applicable to drugs for which reimbursement costs have been established, instead of generic drugs.

Appeals.
In addition to a pharmacy, a pharmacy's representative may file an appeal to the PBM.

Prohibited Conduct.
A PBM may not:

- reimburse a network pharmacy in an amount less than the contract price between the PBM and the insurer, third-party payor, or the prescription drug consortium with which the PBM has contracted;
- require a covered person to pay more at the point of sale for a covered prescription drug than is required by law;
- solicit, coerce, or incentivize a patient to use the PBM's owned or affiliated pharmacies;
- condition or link restrictions on fees relating to credentialing, participation, certification, or enrollment in a PBM's network with a pharmacy's inclusion in the PBM's network for other lines of business;
- exclude a pharmacy from the PBM's network based solely on the pharmacy being newly opened, opened less than a defined amount of time, or a license or location transfer, unless

there is a pending investigation for fraud, waste, and abuse; or
- retaliate against a pharmacist or a 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 a violation of law.

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:
- made disclosures of information that the pharmacist or pharmacy believes is evidence of a violation of state or federal law, rules, or regulation;
- filed complaints with the health plan or PBM; or
- filed complaints against the health plan or the PBM with the OIC.

A pharmacist or pharmacy must make reasonable efforts to limit the disclosure of confidential and proprietary information.

Mail Order Pharmacies.
A PBM must:
- apply the same cost-sharing amounts, 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 PBM's pharmacy network, including mail order pharmacies;
- permit a 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
- for new prescriptions, receive affirmative authorization from a covered person before filling prescriptions through a mail order pharmacy.

If a covered person is using a mail order pharmacy, the PBM must ensure that patients have easy and timely access to prescription counseling by a pharmacist. The PBM must also allow for dispensing at local network pharmacies if:
- the prescription is delayed more than one day after the expected delivery date provided by the mail order pharmacy; and
- the prescription drug arrives in an unusable condition.

Self-Funded Plans.
Self-funded group plans regulated by federal law may elect to participate in state laws relating to PBMs. To elect to participate in this manner, the self-funded plan or its administrator must provide periodic notice to the OIC in a manner and by a date prescribed by the OIC. The notice must attest to the plan's participation and agreement to be bound by the state laws relating to PBMs. A self-funded plan that elects to participate, and any PBM it contracts with, are bound by the state laws in which it elected to participate. The OIC does not have enforcement authority over a PBM's conduct pursuant to a contract with a self-funded group plan.

Before a pharmacy or pharmacist files an appeal involving reimbursement, a PBM must provide,

upon request, a current and accurate list of bank identification numbers, processor control numbers, and pharmacy group identifiers for health plans and self-funded group plans that have opted into PBM regulations and that have a contract or a contract terminated within the past 12 months with the PBM.

Pharmacy Audit Standards.
The type of clerical error for which an auditing entity may not recoup costs does not include errors involving the failure to dispense a medication.

Appropriation: None.

Fiscal Note: Requested on February 13, 2024.

Effective Date: The bill contains multiple effective dates. Please see the bill.