HOUSE BILL REPORT
E2SSB 5213

As Passed House - Amended:
February 29, 2024

Title: An act relating to pharmacy benefit managers.

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 History:
Committee Activity:
Health Care & Wellness: 2/20/24, 2/21/24 [DPA];
Appropriations: 2/23/24, 2/26/24 [DPA(HCW)].
Floor Activity:
Passed House: 2/29/24, 73-20.

Brief Summary of Engrossed Second Substitute Bill
(As Amended by House)

- 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.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 11 members: Representatives Riccelli, Chair; Bateman, Vice Chair; Schmick, Ranking Minority Member; Caldier, Davis, Macri, Maycumber, Simmons, Stonier, Thai and Tharinger.

Minority Report: Do not pass. Signed by 2 members: Representatives Hutchins,

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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.

Assistant Ranking Minority Member; Harris.

Minority Report: Without recommendation. Signed by 4 members: Representatives Bronoske, Graham, Mosbrucker and Orwall.

Staff: Jim Morishima (786-7191).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended by Committee on Health Care & Wellness. Signed by 23 members: Representatives Ormsby, Chair; Bergquist, Vice Chair; Gregerson, Vice Chair; Macri, Vice Chair; Corry, Ranking Minority Member; Chambers, Assistant Ranking Minority Member; Berg, Callan, Chopp, Davis, Fitzgibbon, Lekanoff, Pollet, Riccelli, Ryu, Sandlin, Schmick, Senn, Simmons, Slatter, Springer, Stonier and Tharinger.

Minority Report: Do not pass. Signed by 2 members: Representatives Harris and Rude.

Minority Report: Without recommendation. Signed by 4 members: Representatives Connors, Assistant Ranking Minority Member; Couture, Assistant Ranking Minority Member; Stokesbary and Wilcox.

Staff: Meghan Morris (786-7119).

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.

Registration.
All health care benefit managers (HCBMs), including radiology benefit managers (RBMs) 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 OIC.

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 Amended 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. It is clarified that a union is also exempt from the definition of an HCBM when it acts jointly with an employer to administer a health plan.

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. All service of process to the HCBM must be through the Commissioner, except for actions upon contractor bonds, which may be served upon the Department of Labor and Industries. The appointment of the Commissioner is irrevocable, binds any successor of interest or to the assets or liabilities of the HCBM, and remains in effect as long as any contract made by the HCBM is in force. The service must be accomplished and processed in the same manner as for other insurance-related service.

The HCBM must designate the name, email address, and address of the person to whom the Commissioner must forward legal process. The HCBM must keep this information current and may change the person by filing a new designation.

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 definition of "pharmacy benefit manager (PBM)" is aligned with the definition of HCBM by changing the entities with which the PBM contracts from "insurers or third-party payors" to health carriers, employee benefits programs, and Medicaid managed care organizations. The Prescription Drug Consortium is removed as a contracting entity. 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;
- require or coerce 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 a 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 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 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.

The act neither expands nor restricts the entities subject to laws regulating HCBMs, including PBMs. These laws 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 health plan governed by the federal Employee Retirement Income Security Act of 1974 (ERISA).

Self-funded group plans regulated by the ERISA 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: Available.

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

Staff Summary of Public Testimony (Health Care & Wellness):

(In support) Pharmacists serve an essential role in patient care. Access to care is important because it maximizes health care and improves outcomes. Pharmacy benefit managers (PBMs) set the prices patients pay, but do so in an opaque manner. These practices are running pharmacies out of business and creating pharmacy deserts, even in densely populated areas. Community pharmacies are under threat, which harms patient access. Thriving businesses are closing. The practices of PBMs reduce access and increase price. This is a matter of industry versus patients. There needs to be regulation, transparency, and better policies related to PBMs.

Prohibiting PBMs from forcing patients to use mail-order pharmacies is important. In-person counseling is essential. Pushing consumers to mail-order pharmacies restricts access

to pharmacists and can cause delivery issues and confidentiality breaches. This makes medication adherence more difficult to achieve. Reimbursement practices adversely affect staffing, which is an unsafe and unsustainable practice.

This bill will increase transparency and the fair treatment of patients. It will help both pharmacies and patients. The appeals process in this bill is essential to establish a fair process. The revisions affecting health are benefit managers (HCBMs) are important. They clarify who is an HCBM and who is not. This bill will lead to continuity of care for people with chronic conditions. Unions and self-insured health plans are excluded from this bill unless they opt in.

(Opposed) Pharmacies and health carriers need to work together. The transparency aspects of this bill are not objectionable, but the other provisions of this bill will reduce benefits and increase costs to consumers. Requiring all network pharmacies to have the same cost sharing and fees is concerning. Premiums will be negatively impacted. Patient safety will be compromised.

There should be an exemption to the mail-order provisions of the bill for specialty drugs. Requiring affirmative authorization may lead to delays in care. Specialty drugs are costly and can require special handling. The mail-order provisions in this bill open the door to duplicate dispensing. Taking mail-order pharmacies away will increase costs.

This bill imposes mandates on self-insured plans and violates federal law. A similar law in Oklahoma was stricken down on this basis. Union health plans are in crisis. This bill removes important cost control tools that help unions keep costs down.

The PBMs play a critical role. They negotiate with drug manufacturers, manage networks, and ensure access at good prices. This is a regulated industry already.

This is a complicated bill that needs more deliberation; it needs a study. The effective date of this bill should be extended until 2028 to accommodate health carrier contracting practices.

(Other) State programs already implement many of the provisions in this bill. The provisions add transparency and help the state to manage the pharmacy spend.

The mail-order provisions of this bill are a concern. There should be a delineation between traditional pharmacies and mail-order pharmacies. The products in specialty pharmacies are different and require lots of clinical support. The focus is not only on dispensing, but what happens after.

Staff Summary of Public Testimony (Appropriations):

(In support) The bill increases transparency around pharmacy benefit managers (PBMs)

costs and fees by limiting spread pricing. Stores have fewer pharmacies within them now, especially in rural areas. There were 60 pharmacy closures in 2023 alone and many more will happen in 2024. There is an urgent need to preserve access to pharmacies. Aside from access to care, these closures represent jobs and a loss of tax revenue since patients are forced to use out-of-state mail-in pharmacies. Stores are constantly fighting with PBMs for reimbursements to stay at a feasible operating level. The PBM licensing fees offset the costs of managing this program through the Office of the Insurance Commissioner (OIC). Section 7 saves patients and employers money and expands patient rights. Unions and Employee Retirement Income Security Act of 1974 (ERISA) plans are explicitly exempted unless they choose to opt in.

This bill will allow the OIC to enforce current law more effectively and maintain provider network adequacy standards. The fiscal note shows costs for the OIC to respond to additional complaints, investigations, and enforcement.

When patients are required to use mail order prescriptions there are issues with delivery, confidentiality, inferior care, and it can cost thousands of dollars more per month. Any disruptions in receiving medications can be a health concern. Patients also lose the necessary clinical support and are instead directed to call centers. Many patients need to have a conversation with a pharmacist to make sure they are taking medications correctly. The packaging involved with mail-order drugs is also bad for the environment.

(Opposed) The bill's strict oversight and restrictions of PBM operations reduce efficiencies and increase administrative costs which increase premiums for consumers. The specific reimbursement model will hinder PBMs' ability to negotiate effectively with drug manufacturers. The fiscal note does not reflect the inclusion of including the Public Employees Benefits Board and the School Employees Benefits Board, which will increase costs to the state.

Oklahoma passed a law that contains substantially the same restrictions on PBMs, but that law was struck down by the Tenth Circuit Court of Appeals, holding that the regulations of PBMs was preempted by the ERISA. This would impose costs on both public and private health plans of an estimated $57 more per covered life per year. Allowing ERISA plans to opt in will not insulate the cost impact, and this will cause an increase in benefit plan administration and will increase premiums for all plans. This bill would not increase access to benefits but increase costs to employers and employees through premiums and copays. Shared savings will be eliminated.

People need pharmacists in rural and urban areas and should work together so that services are delivered with quality, cost, and value as the foremost considerations. The prohibitions in section 7 will all add costs to health plans and could impact premiums by more than 10 percent. This would ban spread pricing and require mail order pharmacies that historically charge less than in-person pharmacies to charge the same amount. Without an exemption for specialty drugs, these provisions will increase costs to consumers, the state, and the

plans. If section 7 is not eliminated, then the effective date of the section should be delayed until 2028.

Specialty drugs are usually required through home delivery and used for treating patients with complex rare or life-threatening conditions. If patients do not opt in for various reasons it will lead to delays in therapies, especially when drugs are not readily available. Side effects and these delays lead to unnecessary increases in hospitalizations and cost of care.

Persons Testifying (Health Care & Wellness): (In support) Jane Beyer, Office of the Insurance Commissioner; Patricia Bermúdez, AIDS Healthcare Foundation; Jenny Arnold, Washington State Pharmacy Association; Ryan Oftebro, Kelley-Ross Pharmacy; Jim Freeburg, Patient Coalition of Washington; Jeff Harrell, Cascadia Pharmacy Group; and Robert Queen, Rosauers Supermarkets.

(Opposed) Jennifer Ziegler, Association of Washington Health Care Plans; Gary Strannigan, Premera; Christine Radkey, Regence; Mary Stoll, Pacific Health Coalition; Tom Bryne; Tim O'Donnell, International Brotherhood of Electrical Workers Local 76; Tonia Sorrell-Neal, Pharmaceutical Care Management Association; LuGina Mendez-Harper, Prime Therapeutics; and Sheila Stickel, Northwest Alliance for Affordable Medicine.

(Other) Kate Jelline, Ardon Health Specialty Pharmacy; and Evan Klein, Health Care Authority.

Persons Testifying (Appropriations): (In support) Katie Kolan, AIDS Healthcare Foundation; Jane Beyer, Office of the Insurance Commissioner; Jenny Arnold, Washington State Pharmacy Association; Carolyn Logue, Washington Food Industry Association; and Erik Hansen.

(Opposed) Tonia Sorrell-Neal, Pharmaceutical Care Management Association; Mary Stoll, Pacific Health Coalition; Tom Byrne, affiliated unions; Jennifer Ziegler, Association of Washington Health Care Plans; Gary Strannigan, Premera Blue Cross; LuGina Mendez-Harper, Prime Therapeutics; Christine Radkey, Regence Blue Shield; and Adam Yoest, Washington State Conference of Mason Contractors.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): None.

Persons Signed In To Testify But Not Testifying (Appropriations): None.