FINAL BILL REPORT
E2SSB 5213

C 242 L 24
Synopsis as Enacted

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.).

Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means
House Committee on Health Care & Wellness
House Committee on Appropriations

Background: Health Care Benefit Managers. All health care benefit managers (HCBMs), including pharmacy benefit managers (PBMs), must be registered by the Office of the Insurance Commissioner (OIC). Applications for registration must include the identity of the HCBM and the individuals and entities with a controlling interest in the HCBM, and whether the HCBM does business as a PBM or a different type of benefit manager, in addition to other required information. Registered HCBMs must pay licensing and renewal fees. The fees must be set at an amount that ensures the registration, renewal, and oversight activities of the OIC are self-supporting.

Prior to approving an application, the OIC must find that the HCBM has not committed any act that resulted in the denial, suspension, or revocation of a registration; has the capacity to comply with state and federal laws' and has designated a person responsible for such compliance.

A HCBM may not provide services to a health carrier or an employee benefits program without a written agreement describing the rights and responsibilities of the parties. The HCBM must file with the OIC every benefit management contract and contract amendment between the HCBM and a provider, pharmacy, pharmacy services administration organization, or other HCBM.

Pharmacy Benefit Manager Regulation. A PBM is a person that contracts with pharmacies

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on behalf of an insurer, third party payer, or the prescription drug purchasing consortium to:

- process claims;
- provide retail network management;
- pay pharmacies or pharmacists;
- negotiate rebates;
- manage pharmacy networks; or
- make credentialing determinations.

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.

Summary: A PBM may not:

- reimburse a network pharmacy an amount less than the contract price between the PBM and the third-party payor the PBM has contracted with to provide a pharmacy benefits plan or program;
- exclude a pharmacy from the network on the basis that the pharmacy is new, has only been open for a limited time, or has transferred locations, unless there is a pending investigation for fraud, waste, and abuse;
- require a covered person to pay more for a drug than the lesser of the applicable cost sharing for the drug or the amount the person would pay if buying the drug in cash; or
- require or coerce a covered person to use a pharmacy owned or affiliated with the PBM.

A PBM must:

- apply the same fees, utilization review, and days allowance regardless of which participating pharmacy a covered person uses;
- permit the covered person to receive delivery or mail order of a medication 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 issued after January 1, 2026, receive affirmative authorization

from a covered person before filling prescriptions through a mail order pharmacy.

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

A pharmacy benefit manager must establish a process by which a network pharmacy, or its representative, may appeal its reimbursement for a drug. A network pharmacy may appeal a reimbursement cost for a drug if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug. Before a pharmacy files an appeal, it may request, and the PBM must provide a list of bank identification numbers, processor control numbers, and pharmacy group identifiers for health plans with which it has a current contract or had a contract that was terminated in the past 12 months to provide pharmacy benefit management services.

A PBM may not charge a pharmacy a fee related to credentialing, participation, certification, or enrollment in a network, and it may not condition or link restrictions on fees related to credentialing, participation, certification, or enrollment in a PBM's pharmacy network with a pharmacy's inclusion in the PBM's pharmacy network for other lines of business.

A PBM may not retaliate against a pharmacy or pharmacist for disclosing information in court, an administrative hearing, legislative hearing, or to a law enforcement agency if the pharmacy or pharmacist has a good faith belief the information is evidence of a violation of a state or federal law, rule, or regulation. Retaliatory actions include cancellation of, restriction of, or refusal to renew or offer a contract to a pharmacy. A pharmacist or pharmacy shall make reasonable efforts to limit the disclosure of confidential and proprietary information.

A HCBM must provide a copy of its certificate of registration with the Washington Secretary of State as part of its registration with the OIC. 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.

Any entity that performs provider credentialing or recredentialing, but no other functions of HCBM, is not considered an HCBM. A union is also exempt from the definition of an HCBM when it acts jointly with an employer to administer a health plan.

OIC shall respond to and investigate complaints related to the conduct of a HCBM directly, without requiring that the complaint be pursued exclusively through a contracting carrier.

The definition of 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 PBM performs include negotiating discounts or other price concessions from manufacturers and establishing pharmacy networks.

Health plans offered to public employees are subject to the HCBM and PBM requirements in this act and in Chapter 48.200 RCW.

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 health plans regulated by ERISA may elect to participate in the PBM regulations in this act. OIC does not have enforcement authority related to a PBM's conduct pursuant to a contract with a self-funded group health plan that has elected to participate in this act.

Votes on Final Passage:

Senate	41	8	
House	73	20	(House amended)
Senate	45	4	(Senate concurred)

Effective: June 6, 2024
January 1, 2026 (Section 5, Sections 7-9)