SENATE BILL REPORT
E2SSB 5213

As Amended by House, 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 & Long Term Care: 2/03/23, 2/17/23 [DPS-WM, w/oRec]. Ways & Means: 2/21/23, 2/23/23 [DP2S, w/oRec].

Floor Activity: Passed Senate: 2/12/24, 41-8.
Passed House: 2/29/24, 73-20.

Brief Summary of Engrossed Second Substitute Bill

- Imposes certain requirements on pharmacy benefit manager business practices.
- Modifies the reimbursement appeal process to allow pharmacies to challenge the reimbursement amount received from a pharmacy benefit manager for all drugs.
- Prohibits retaliatory actions by a pharmacy benefit manager against a pharmacy under certain circumstances.
- Makes several modifications to the health care benefit manager registration process.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 5213 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

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.

Signed by Senators Cleveland, Chair; Robinson, Vice Chair; Muzzall, Assistant Ranking Member; Conway, Dhingra, Randall and Van De Wege.

Minority Report: That it be referred without recommendation.
Signed by Senators Rivers, Ranking Member; Holy and Padden.

Staff: Greg Attanasio (786-7410)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 5213 be substituted therefor, and the second substitute bill do pass.
Signed by Senators Rolfes, Chair; Robinson, Vice Chair, Operating & Revenue; Mullet, Vice Chair, Capital; Wilson, L., Ranking Member, Operating; Gildon, Assistant Ranking Member, Operating; Schoesler, Ranking Member, Capital; Rivers, Assistant Ranking Member, Capital; Warnick, Assistant Ranking Member, Capital; Billig, Boehnke, Conway, Dhingra, Hasegawa, Hunt, Keiser, Nguyen, Pedersen, Saldaña, Torres, Van De Wege and Wellman.

Minority Report: That it be referred without recommendation.
Signed by Senators Braun, Muzzall and Wagoner.

Staff: Sandy Stith (786-7710)

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 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 of Engrossed Second Substitute Bill: A PBM may not:

- reimburse a network pharmacy an amount less than the contract price between the pharmacy benefit manager and the third-party payor the pharmacy benefit manager 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
- solicit, coerce, or incentivize a covered person to use a pharmacy owned or affiliated with the PBM.

A PBM must:

- apply the same copays, fees, 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; 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 State Secretary of State as part of its registration with the OIC. An HCBM must appoint the insurance commissioner as its attorney to receive service of, and upon whom service must be served, all legal process issued against it in this state upon causes of action arising within this state.

Any entity that performs provider credentialing or recredentialing, but no other functions of HCBM, is not considered an HCBM.

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.

Health plans offered to public employees are subject to the HCBM and PBM requirements

in this act and in Chapter 48.200 RCW.

Self-funded group health plans 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.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: The bill contains several effective dates. Please refer to the bill.

Staff Summary of Public Testimony on Original Bill (Health & Long Term Care): *The committee recommended a different version of the bill than what was heard.* PRO: Prohibiting spread pricing has the potential to save millions of dollars. PBMs control all aspects of obtaining drugs including price, who fills the prescription, and what drugs are available to patients. This bill builds on existing regulations and adds additional accountability and transparency. PBMs continue to charge fees to pharmacy because the currently law only applies to state regulated plans. PBM practices are forcing community pharmacies to close. State laws should apply to all PBMs regardless of who they contract with. Patients should have the ability to choose where and when they obtain their prescriptions. Mail order pharmacies do not offer the same services that community pharmacies do.

CON: PBMs are essential to keeping drug prices affordable. Independent pharmacies make more money from higher drug costs. Requiring an opt-in for mail order pharmacy services is confusing for current customers. Plans must be able to manage costs for provider-administered drugs. This bill limits the ability for plans to design affordable networks.

OTHER: Under the bill, pharmacies can refuse to fill a prescription if the reimbursement is too low. This puts consumer in the middle of dispute between the pharmacy and the PBM.

Persons Testifying (Health & Long Term Care): PRO: Senator Patty Kuderer, Prime Sponsor; Jenny Arnold, Washington State Pharmacy Association; Ryan Oftebro, Kelley-Ross Pharmacy; Jack Holt, Hi-School Pharmacy Services; Kaitlynn Johnson, Tick Klock Drug; Nathan Johnson, Tick Klock Drug; Erin Callahan, Diabetes Patient Advocacy Coalition; Jim Freeburg, Patient Coalition of Washington.

CON: Angela Henderson; Lua Pritchard Pritchard, Executive Director of the Wa State Asia Pacific Alliance Center; Janine Terrano, CEO and Owner of Topia Technology; LuGina Mendez Harper, Prime Therapeutics; Timothy O'Donnell Sr., I.B.E.W. Local 76 Business Manager/Chairman; Jennifer Ziegler, Association of Washington Health Care Plans; Chris

Bandoli, America's Health Insurance Plans; Tirhas Gebru; Jonathan Edelheit, Global Health Resources.

OTHER: Jane Beyer, Office of the Insurance Commissioner.

Persons Signed In To Testify But Not Testifying (Health & Long Term Care): PRO: Laura Boudreau, AIDS Healthcare Foundation; Lisa Nelson, Washington Association for Community Health; Rob Geddes, Albertsons Companies, Inc.; Rachel Wittenauer.

CON: Fred Brown, National Labor Alliance of Healthcare Coalitions.

Staff Summary of Public Testimony on First Substitute (Ways & Means): *The committee recommended a different version of the bill than what was heard.* OTHER: PBMs keep finding loopholes in the legislative efforts to approach the use of nonresident pharmacies and continue to have record earnings. Constituents would like to see the current version of this bill return to its original version. The changes made stripped away patient protections and accountability provisions, removed exclusion for specialty drugs, and failed to address the widespread practice of patient steering. Patients rely on their prescriptions for various reasons, including treatment of serious, chronic, and life-threatening illness. Since the pandemic, there has been an increase in mail order delivery for patients. For some, mail order auto delivery is helpful in receiving medications in a timely manner. However, mail order delivery can cost around 40% more than getting prescriptions from a local pharmacy. Additionally, medications that require specific temperature management are delivered in Styrofoam coolers which contribute to pollution. The timing of delivery can be inconvenient for patients and there is no recourse for poor service. There are concerns regarding language and practical applications in this bill. Affirmative authorization before filling a prescription can create a barrier for those who receive maintenance medications if they are required to receive authorization each time a refill is needed. This legislation should avoid double-dispensing medications.

Persons Testifying (Ways & Means): OTHER: Heather Chapman, Ardon Health Specialty Pharmacy; Laura Boudreau, AIDS Healthcare Foundation; KARI VANDERHOUWEN, DUVALL FAMILY DRUGS; Dedi Little, Washington State Pharmacy Association; Erik Hansen, Self; Tonia Sorrell-Neal, Pharmaceutical Care Management Association; Isaac Kastama, Prime Therapeutics.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.

EFFECT OF HOUSE AMENDMENT(S):

- 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 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.