

ESSB 5557 - H AMD 439

By Representative Short

ADOPTED 4/14/2015

1 Strike everything after the enacting clause and insert the
2 following:

3 "NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43
4 RCW to read as follows:

5 (1) For health plans issued or renewed on or after January 1,
6 2017:

7 (a) Benefits shall not be denied for any health care service
8 performed by a pharmacist licensed under chapter 18.64 RCW if:

9 (i) The service performed was within the lawful scope of such
10 person's license;

11 (ii) The plan would have provided benefits if the service had
12 been performed by a physician licensed under chapter 18.71 or 18.57
13 RCW, an advanced registered nurse practitioner licensed under chapter
14 18.79 RCW, or a physician's assistant licensed under chapter 18.71A
15 or 18.57A RCW; and

16 (iii) The pharmacist is included in the plan's network of
17 participating providers; and

18 (b) The health plan must include an adequate number of
19 pharmacists in its network of participating medical providers.

20 (2) The participation of pharmacies in the plan network's drug
21 benefit does not satisfy the requirement that plans include
22 pharmacists in their networks of participating medical providers.

23 (3) For health benefit plans issued or renewed on or after
24 January 1, 2016, but before January 1, 2017, health plans that
25 delegate credentialing agreements to contracted health care
26 facilities must accept credentialing for pharmacists employed or
27 contracted by those facilities. Health plans must reimburse
28 facilities for covered services provided by network pharmacists
29 within the pharmacists' scope of practice per negotiations with the
30 facility.

31 (4) This section does not supersede the requirements of RCW
32 48.43.045.

1 **Sec. 2.** RCW 48.43.045 and 2007 c 253 s 12 are each amended to
2 read as follows:

3 (1) Every health plan delivered, issued for delivery, or renewed
4 by a health carrier on and after January 1, 1996, shall:

5 (a) Permit every category of health care provider to provide
6 health services or care (~~for conditions~~) included in the basic
7 (~~health plan services~~) essential health benefits benchmark plan
8 established by the commissioner consistent with RCW 48.43.715, to the
9 extent that:

10 (i) The provision of such health services or care is within the
11 health care providers' permitted scope of practice; (~~and~~)

12 (ii) The providers agree to abide by standards related to:

13 (A) Provision, utilization review, and cost containment of health
14 services;

15 (B) Management and administrative procedures; and

16 (C) Provision of cost-effective and clinically efficacious health
17 services; and

18 (iii) The plan covers such services or care in the essential
19 health benefits benchmark plan. The reference to the essential health
20 benefits does not create a mandate to cover a service that is
21 otherwise not a covered benefit.

22 (b) Annually report the names and addresses of all officers,
23 directors, or trustees of the health carrier during the preceding
24 year, and the amount of wages, expense reimbursements, or other
25 payments to such individuals, unless substantially similar
26 information is filed with the commissioner or the national
27 association of insurance commissioners. This requirement does not
28 apply to a foreign or alien insurer regulated under chapter 48.20 or
29 48.21 RCW that files a supplemental compensation exhibit in its
30 annual statement as required by law.

31 (2) The requirements of subsection (1)(a) of this section do not
32 apply to a licensed health care profession regulated under Title 18
33 RCW when the licensing statute for the profession states that such
34 requirements do not apply.

35 NEW SECTION. **Sec. 3.** (1) The insurance commissioner shall
36 designate a lead organization to establish and facilitate an advisory
37 committee to implement the provisions of section 1 of this act. The
38 lead organization and advisory committee shall develop best practice
39 recommendations on standards for credentialing, privileging, billing,

1 and payment processes to ensure pharmacists are adequately included
2 and appropriately utilized in participating provider networks of
3 health plans. In developing these standards, the committee shall also
4 discuss topics as they relate to implementation including current
5 credentialing requirements for health care providers consistent with
6 chapter 18.64 RCW, existing processes of similarly situated health
7 care providers, pharmacist training, care coordination, and the role
8 of pharmacist prescriptive authority agreements pursuant to WAC
9 246-863-100.

10 (2) The lead organization shall create an advisory committee
11 including, but not limited to, representatives of the following
12 stakeholders:

- 13 (a) The insurance commissioner or designee;
- 14 (b) The secretary of health or designee;
- 15 (c) An organization representing pharmacists;
- 16 (d) An organization representing physicians;
- 17 (e) An organization representing hospitals;
- 18 (f) A hospital conducting internal credentialing of pharmacists;
- 19 (g) A clinic with pharmacists providing medical services;
- 20 (h) A community pharmacy with pharmacists providing medical
21 services;
- 22 (i) The two largest health carriers in Washington based upon
23 enrollment;
- 24 (j) A health care system that coordinates care and coverage;
- 25 (k) A school or college of pharmacy in Washington;
- 26 (l) A representative from a pharmacy benefit manager or
27 organization that represents pharmacy benefit managers; and
- 28 (m) Other representatives appointed by the insurance
29 commissioner.

30 (3) No later than December 1, 2015, the advisory committee shall
31 present initial best practice recommendations to the insurance
32 commissioner and the department of health. If necessary, the
33 insurance commissioner or department of health may adopt rules to
34 implement the standards developed by the lead organization and
35 advisory committee. The advisory committee will remain intact to
36 assist the insurance commissioner or department of health in rule
37 making. The rules adopted by the insurance commissioner or the
38 department of health must be consistent with the recommendations
39 developed by the advisory committee.

1 (4) For purposes of this section, "lead organization" means a
2 private sector organization or organizations designated by the
3 insurance commissioner to lead development of processes, guidelines,
4 and standards to streamline health care administration to be adopted
5 by payors and providers of health care services operating in the
6 state."

7 Correct the title.

EFFECT: Delays the prohibition against a health plan denying benefits provided by a pharmacist until the 2017 plan year. Beginning in the 2017 plan year, requires health plans to include an adequate number of pharmacists in their networks of participating medical providers.

For the 2016 plan year: (1) Requires health plans that delegate credentialing agreements to contracted health care facilities to accept credentialing for pharmacists employed or contracted by those facilities, and (2) requires health plans to reimburse the facilities for covered services provided by network pharmacists within the pharmacists' scope of practice per negotiations with the facility.

Requires the Insurance Commissioner to designate a lead organization to establish and facilitate an advisory committee to implement the provisions of the act dealing with reimbursement for pharmacist services. Requires the lead organization and advisory committee to develop, by December 1, 2015, best practice recommendations on standards for credentialing privileging, billing, and payment processes to ensure pharmacists are adequately included and appropriately utilized in participating provider networks. Requires the advisory committee to discuss topics including current credentialing requirements for pharmacists, existing processes for similarly situated providers, pharmacist training, care coordination, and the role of pharmacist prescriptive authority agreements. Allows the Department of Health and the Insurance Commissioner to adopt rules to implement the standards developed by the lead organization and the advisory committee.

Removes the requirement that large group market health plans use a definition of essential health benefits authorized under federal law for purposes of the Every Category of Provider Law. Requires that only services or care in the essential health benefits benchmark plan that are covered by the health plan are subject to the Every Category of Provider Law.

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