Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1562

Brief Description: Concerning health care benefit management.

Sponsors: Representatives Stonier, DeBolt, Harris, Macri, Caldier, Robinson, Thai, Riccelli, Tharinger, Jinkins, Kloba and Slatter.

Brief Summary of Bill

- Requires all health care benefit managers, including radiology benefit managers and pharmacy benefit managers, to be licensed by the Office of the Insurance Commissioner.
- Imposes filing, recordkeeping, and administrative requirements on health care benefit managers.
- Prohibits certain conduct by pharmacy benefit managers.

Hearing Date: 1/21/20

Staff: Jim Morishima (786-7191).

Background:

<u>I. Benefit Managers</u>.

A benefit manager is an entity that contracts with an insurance carrier to administer part of a health benefit plan or other insurance contract. There are two types of benefit managers that are subject to state regulation: radiology benefit managers (RBMs) and pharmacy benefit managers (PBMs).

An RBM owned by a health carrier or acting as a subcontractor to a health carrier must register with the Department of Revenue's Business Licensing Program. To register, an RBM must submit an application containing certain identifying information and pay a registration fee of $200.

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

A PBM must register with the Office of the Insurance Commissioner (OIC) to do business in the state. State-registered PBMs are subject to a variety of requirements. For example, a PBM must establish a process with which a pharmacy may appeal the reimbursement amount it receives for certain drugs. If the pharmacy prevails, the PBM must adjust the reimbursement amount. If the pharmacy is a critical access pharmacy as defined in rules adopted by the Health Care Authority, the adjustment only applies to critical access hospitals.

II. Prior Authorization.

A health carrier may not require prior authorization for an initial evaluation and management visit and up to six consecutive treatment visits in a new episode of care for the following types of services: chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, or speech and hearing therapy. The visits are subject to the carrier's medical necessity standards and are subject to any quantitative treatment limits of the health plan.

Summary of Bill:

I. Licensing Health Care Benefit Managers.

All health care benefit managers (HCBMs), including radiology benefit managers (RBMs) and pharmacy benefit managers (PBMs), must be licensed by the Office of the Insurance Commissioner (OIC). Applications for licensure must include:

- 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;
- whether the HCBM does business as a PBM, an RBM, a different type of benefit manager, or a combination of different types of benefit manager; and
- any other information reasonably required by the OIC.

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 license; and
- has the capacity to comply with state and federal laws and has designated a person responsible for such compliance.

Licensed HCBMs must pay licensing and renewal fees in an amount established by the OIC in rule. The fees must be set at an amount that ensures the licensing, renewal, and oversight activities of the OIC are self-supporting.

An HCBM is defined as any 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, including a PBM or an RBM, that directly or indirectly impacts the determination or utilization of benefits for, or patient access to, health care services, drugs, and supplies, including:

- prior authorization or preauthorization of benefits or care;
- certification of benefits of care;
- medical necessity determinations;
- utilization review;
- benefit determinations;

- claims processing and repricing;
- provider credentialing or re-credentialing;
- dispute resolution, grievances, or appeals relating to determinations; and
- provider network management.

II. Health Care Benefit Manager Requirements.

A. Filing and Record-Keeping Requirements.

A licensed HCBM must retain a record of all transactions completed under its license for seven years. The records must be kept available and open to inspection by the OIC for the seven year period.

The HCBM must also file with the OIC every benefit management contract and every contract between the HCBM and any other person directly or indirectly in support of the contract. The contracts must be filed at least 30 days prior to use. The contracts must be available to the public and available on the OIC's web site, except that contract compensation provisions are confidential, unless a reasonable person would believe they encourage HCBMs to deny, delay, or limit benefits. The method or formula for compensation is likewise not exempt from disclosure.

B. Benefit Administration Requirements.

A licensed HCBM has a fiduciary duty to patients and beneficiaries to perform services in accordance with state and federal law.

The HCBM may not penalize, require, or provide incentives to beneficiaries as an incentive to use a specific provider or pharmacy in which a carrier, program, or HCBM has an ownership interest. This prohibition does not apply to the extent specified in rule by the OIC if the conduct is necessary to the operation of a health benefit plan or program, such as a staff model health maintenance organization that depends upon patient use of owned facilities.

The HCBM may not deny a benefit to, impose a cost or limitation on, or collect debt from a beneficiary if the denial, cost, limitation, or debt arose from a violation of laws relating to HCBMs.

For purposes of prior, concurrent, or post-service authorization for up to six consecutive treatment visits in a new episode of care for chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, or speech and hearing therapy, a medical necessity determination by the primary care provider, or portal of entry provider, is sufficient; no additional referrals or medical necessity determinations may be required.

III. Pharmacy Benefit Manager Requirements.

A PBM may not:

- cause or 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;

- require pharmacy accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to requirements of the Pharmacy Quality Assurance Commission (PQAC), unless approved by the PQAC;
- 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 pharmacist for services after adjudication of the claim, unless:
    - the original claim was submitted fraudulently;
    - the original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the services; or
    - the pharmacist services were not properly rendered by the pharmacy or pharmacist.

For purposes of payment adjustment after appeal, "critical access pharmacy" is defined as a pharmacy that is outside a 10-mile radius of any other pharmacy or a pharmacy within a 10-mile radius of another pharmacy the closure of which could result in impaired access for a rural area, in which both pharmacies must be considered critical access pharmacies.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed, except for sections 1 through 16, relating to licensing and specifying requirements for health care benefit managers, which take effect January 1, 2021.