Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

2SSB 5601

Brief Description: Regulating health care benefit managers.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Rolfes, Short, Keiser, Liias, Kuderer, Walsh, Hobbs, King, Warnick, Honeyford and Conway).

Brief Summary of Second Substitute Bill

- Requires health care benefit managers to register with the Insurance Commissioner.
- Imposes requirements on health care benefit managers and pharmacy benefit managers.
- Establishes a work group on performance-based pharmacy contracts.

Hearing Date: 2/25/20

Staff: Jim Morishima (786-7191).

Background:

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.

A PBM must register with the Insurance Commissioner to do business in the state. State-registered PBMs are subject to a variety of requirements. For example, a PBM may not place a drug on its cost list unless there are least two therapeutically equivalent multi-source drugs, or one generic drug, generally available from wholesalers. A PBM must establish a process with

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which a pharmacy may appeal the reimbursement amount it receives for certain drugs. If the pharmacy prevails, the PBM must adjust the reimbursement amount.

Summary of Bill:

I. Benefit Manager Registration.

All health care benefit managers (HCBMs), including radiology benefit managers (RBMs) and pharmacy benefit managers (PBMs), must be registered by the Insurance Commissioner (Commissioner). Applications for registration 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;
- 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.

Prior to approving an application, the Commissioner must find that the HCBM:

- has not committed any act that resulted in the denial, suspension, or revocation of a registration; and
- has the capacity to comply with state and federal laws and has designated a person responsible for such compliance.

Registered HCBMs must pay licensing and renewal fees in an amount established by the Commissioner in rule. The fees must be set at an amount that ensures the registration, renewal, and oversight activities of the Commissioner 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, 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;
- outcome management;
- provider credentialing or re-credentialing;
- payment or authorization of payment to providers and facilities for services or procedures;
- dispute resolution, grievances, or appeals relating to determinations;
- provider network management; and
- disease management.

An HCBM does not include:

- health insurers, including health care service contractors and health maintenance organizations;

- the Public Employees' Benefits Board and the School Employees' Benefits Board;
- discount plans;
- direct patient-provider primary care practices;
- an employer administering its employee benefit plan or the employee benefit plan of an affiliated employer under common management and control;
- a union administering a benefit plan on behalf of its members;
- an insurance producer;
- a creditor acting on behalf of its debtors with respect to insurance, covering a debt between the creditor and its debtors;
- a behavioral health administrative services organization or other county-managed entity that has been approved by the Health Care Authority to perform delegated functions on behalf of a carrier;
- a hospital or ambulatory surgical facility;
- the Robert Bree Collaborative;
- the Health Technology Clinical Committee; and
- the Prescription Drug Purchasing Consortium.

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 Commissioner for the seven year period.

An 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 Commissioner every benefit management contract and contract amendment between the HCBM and a provider, pharmacy, pharmacy services administration organization, or other HCBM. The contracts must be filed within 30 days of the effective date of the contract or contract amendment. The contracts are confidential and not subject to public inspection or public disclosure.

A health carrier must file with the Commissioner every contract and contract amendment between the carrier and any HCBM within 30 days of the effective date of the contract or contract amendment. The contracts are confidential and not subject to public inspection or public disclosure. Enrollees in health plans issued on or after January 1, 2022, must be notified in writing of each HCBM contracted within the carrier to provide any benefit management services in the administration of the plan.

B. Enforcement.

The Commissioner may take action against an HCBM or contracting carrier if the Commissioner finds that the HCBM has:
- violated any insurance law or any rule, subpoena, or order of the Commissioner or another state's insurance commissioner;
- failed to renew its registration or pay registration or renewal fees;

- provided incorrect, misleading, incomplete, or materially untrue information to the Commissioner, a carrier, or a beneficiary;
- used fraudulent, coercive, or dishonest practices;
- demonstrated incompetence or financial irresponsibility; or
- had a HCBM registration or its equivalent denied, suspended, or revoked in any other jurisdiction.

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. Within 15 days of receipt of an inquiry by the Commissioner, the HCBM must provide a complete response, including providing a statement or testimony, producing its accounts, records, and files, responding to complaints, or responding to surveys and general requests.

The Commissioner may take any of the following actions based on an adverse finding against an HCBM:
- place on probation, suspend, revoke, or refuse to issue or renew the HCBM's registration;
- issue a cease and desist order against the HCBM and contracting carrier;
- fine the HCBM or the contracting carrier up to $5,000 per violation—the contracting carrier is only liable for actions conducted under the contract;
- issue an order requiring corrective action against the HCBM or the contracting carrier; or
- temporarily suspend, based on a finding that the public safety or welfare requires and emergency action, the HCBM's registration by mail or by personal service upon the HCBM no less than three days prior to the suspension date—the temporary suspension continues until proceedings for revocation are concluded.

A stay of action is not available for actions the Commissioner takes by cease and desist order, by order on hearing, or by temporary suspension.

Health carriers and employee benefits programs are responsible for the compliance of any person or organization acting directly or indirectly on behalf of, or at the direction of, the carrier or program or acting pursuant to carrier or program standards or requirements concerning the coverage of, payment for, or provision of health care benefits, services, drugs, and supplies. A carrier or program contracting with an HCBM is responsible for the HCBM's violations, including the failure to produce records requested or required by the Commissioner. No carrier or program may offer as a defense that the violation arose from the act or omission of an HCBM or other person acting on behalf or at the direction of the carrier, rather than from the direct act or omission of the carrier or program.

III. Pharmacy Benefit Manager Requirements.

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.

IV. Work Group.

Subject to appropriated funds, a performance-based pharmacy contract work group is established. Members of the work group are appointed by the Governor and must represent each of the following:

- the Prescription Drug Consortium;
- the Pharmacy Quality Assurance Commission;
- an association representing independent pharmacies;
- an association representing chain pharmacies;
- each health carrier offering at least one health plan in the commercial market;
- each health carrier offering at least one health plan to Medicaid enrollees;
- an association representing health carriers;
- the Public Employees' Benefits Board or the School Employees' Benefits Board;
- the Health Care Authority;
- a PBM; and
- a state agency that purchases health care services and drugs for a selected population.

The work group must review the use of performance-based contracts in the delivery of pharmacy benefits and develop recommendations on designs and use of performance-based contracts. The work group must report its recommendations to the Legislature and Governor by December 1, 2020. The recommendations must include any statutory changes necessary to implement the recommendations.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on February 11, 2020.

Effective Date: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except for section 20, relating to Insurance Commissioner rulemaking, which takes effect on January 1, 2021, and sections 1 through 19, relating to requirements for registered health care benefit managers, which take effect on January 1, 2022.