HOUSE BILL REPORT
2SSB 5601

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to health care benefit managers.

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 History:
Committee Activity:
Health Care & Wellness: 2/25/20, 2/27/20 [DPA].

Brief Summary of Second Substitute Bill
(As Amended by Committee)

- 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 pharmacy contracts.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 14 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Chambers, Chopp, Davis, DeBolt, Harris, Maycumber, Riccelli, Robinson, Stonier, Thai and Tharinger.

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

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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 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 Amended 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 recredentialing;
- 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 or any person responsible for the conduct of the HCBM's affairs, other than an employee benefits program:

- 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 an 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 work group on pharmacy contracts is established. The Governor must appoint a member of the work group representing each of the following:

- the Prescription Drug Purchasing Consortium;
- the Pharmacy Quality Assurance Commission;
- an association representing pharmacies;
- an association representing hospital pharmacies;
- a health carrier offering at least one health plan in the commercial market;
- a health maintenance organization offering at least one health plan in the commercial market;
- an association representing health carriers;
- the Health Care Authority on behalf of the Public Employees' Benefits Board or the School Employees' Benefits Board;
- the Health Care Authority on behalf of the state Medicaid program;
- a PBM; and
- the Office of the Insurance Commissioner.

The work group must also include one member from each of the two largest caucuses in the House of Representatives, appointed by the Speaker of the House, and one member from each of the two largest caucuses of the Senate, appointed by the President of the Senate.

The work group must:

- review the use of financial incentives, penalties, and other pharmacy use requirements by PBMs that are designed to direct covered persons to pharmacies that are an affiliate of the PBM and develop recommendations on preventing PBMs from requiring or incentivizing covered persons to use affiliated pharmacies;
- collect and review the following information on contracts in effect, and fees charged, between January 1, 2013, and December 31, 2019, from PBMs doing business in Washington:
    - a description of each fee charged to pharmacists or pharmacies as part of the PBM's contractual relationship, along with an explanation of what necessitates the fees, the date upon which the fees commenced, and the methodology used to increase the fees; and
    - the use of performance-based audit standards as part of the PBM's contracts with pharmacists or pharmacies, both owned and nonowned, and when the performance-based standards went into effect;
- review the rate pharmacies pay for prescription drugs, what pharmacies are contracted to be reimbursed for the prescription drugs, how performance-based measures impact the final reimbursement that pharmacies receive for prescription drugs, and whether mail order prescriptions receive the same reimbursement rate as prescriptions filled in-person; and
- 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 submit a progress report to the Legislature and Governor by January 1, 2021, and a final report by September 1, 2021. The final report must include any statutory changes necessary to implement the recommendations.

Amended Bill Compared to Second Substitute Bill:

The amended bill:

- exempts employee benefits programs from the enforcement actions the Insurance Commissioner is authorized to impose;
- requires the work group to review, in addition to performance-based contracts: (1) pharmacy benefit practices designed to direct enrollees to affiliate pharmacies; (2) information on fees and performance-based audit standards used by pharmacy benefit managers between January 1, 2013, and December 31, 2019; (3) the rate pharmacies pay for prescription drugs; (4) reimbursement amounts for prescription drugs; (5) how performance-based measures impact reimbursement amounts; and (6) whether mail order prescriptions are reimbursed at the same rate as in-person prescriptions;
- changes the membership of the work group by: (1) removing the representative of a state agency that purchases health care services and drugs for a selected population; (2) removing the representative of a health carrier offering health plans to Medicaid enrollees; (3) adding a representative from the Office of the Insurance Commissioner; (4) adding a representative from each of the two largest caucuses of the House of Representatives and the Senate; (5) changing the composition of the pharmacy members to one representing pharmacies in general and one representing hospital pharmacies, instead of one representing independent pharmacies and one representing chain pharmacies; (6) reducing the number of health carrier members to one representing health carriers offering coverage in the state and one representing a

health maintenance organization offering coverage in the state, instead of one representative from every health carrier offering coverage in the state; (7) clarifying that the Public Employees' Benefits Board and the School Employees' Benefits Board be represented by the Health Care Authority; and (8) clarifying that the second Health Care Authority member represent the state Medicaid program; and
- delays the work group report until September 1, 2021, with a progress report due by January 1, 2021.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: 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.

Staff Summary of Public Testimony:

(In support) This bill is about accountability and transparency. Most people have dealt with a health care benefit manager (HCBM) in some capacity. Their role has increased over time, replacing functions that used to be carried out by the health carriers themselves. They can deny people care and needed medications outside of the boundaries of the patient-provider relationship.

Pharmacies have faced a lot of frustration with fees. Pharmacy benefit managers (PBMs) are constantly changing the types of fees they impose, so all fees should be prohibited.

Pharmacy benefit managers are categorizing essential medications as specialty medications, which means they are not available in community hospitals. Becoming a specialty pharmacy is expensive and pharmacies often receive a lower reimbursement rate once they have completed the process. Most pharmacies choose to walk away, which is a loss to the communities they serve. Pharmacy benefit managers engage in practices that end up costing patients more, such as claw-backs, requiring brand name drugs when generic drugs are available, and forcing the use of mail-order pharmacies. Plus, PBMs often retaliate against pharmacies that complain, destroying practices with no remorse.

This bill is the product of extensive stakeholder meetings. This bill is more limited than the House companion. There was a lot of give and take to keep this a strong bill. This bill has registration instead of licensing and an enforcement mechanism, although the work group could use some improvement. The deadline for the work group's work should be extended.

(Opposed) None.

(Other) Health care benefit managers help manage risk and improve outcomes. They provide expertise, help with utilization management, and ensure the right care is received at the right time. There is a natural tension between HCBMs and providers. This bill strikes a balance.

This bill is the product of stakeholder meetings with adult supervision. It will be the strongest law in the country, with nothing else like it. The bill applies broadly, stops just short of full licensing, and requires disclosures of contracts, fees, affiliates, specialties, and contact information. The appeals process for small pharmacies is unaffected by this bill. The work group is also significant. Although not perfect, it was difficult to get to agreement and lots of concessions were made. This bill should therefore be moved forward as close as possible to how it left the Senate, or it may fall apart.

Persons Testifying: (In support) Senator Rolfes, prime sponsor; Senator Short; Lori Grassi, Washington State Chiropractic Association; Ryan Oftebro, Kelley Ross Pharmacy; and Lonnie Johns-Brown, Office of the Insurance Commissioner.

(Other) Christine Brewer, Washington Association of Healthcare Plans; Lugina Mendez Harper, Prime Therapeutics; and Carrie Tellefson, Pharmaceutical Care Management Association.

Persons Signed In To Testify But Not Testifying: None.