SENATE BILL REPORT
SB 5601

As of February 19, 2019

Title: An act relating to health care benefit management.

Brief Description: Concerning health care benefit management.

Sponsors: Senators Rolfes, Short, Keiser, Liias, Kuderer, Walsh, Hobbs, King, Warnick, Honeyford and Conway.

Brief History:
Committee Activity: Health & Long Term Care: 2/18/19.

Brief Summary of Bill

- Requires anyone practicing as a health care benefit manager (HCBM) in Washington to obtain a license.
- Regulates the practice of HCBMs, including HCBMs doing business as a pharmacy benefit manager.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Staff: Evan Klein (786-7483)

Background: A pharmacy benefit manager (PBM) is any person that contracts with pharmacies on behalf of an insurer, a third-party payor, or the prescription drug purchasing consortium to:

- process claims for prescription drugs or medical supplies or provide retail network management for pharmacies or pharmacists;
- pay pharmacies or pharmacists for prescription drugs or medical supplies; or
- negotiate rebates with manufacturers for drugs paid for or procured.

To conduct business in Washington, a PBM is required to register with the insurance commissioner (commissioner), to develop an appeals process for pharmacies, and to follow specified standards for auditing pharmacy claims.

A radiology benefit manager (RBM) is any person who contracts with or is owned by a carrier or third-party payor to process claims for services and procedures performed by a

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licensed radiologist, or to pay or authorize payment to radiology clinics, radiologists, or advanced diagnostic imaging service providers for services or procedures. Anyone acting as a RBM must be registered with the Department of Revenue.

In 2018, the Legislature prohibited health carriers from requiring prior authorization for initial evaluation and management visits, and up to six consecutive treatment visits in a new episode of care of chiropractic, physical therapy, occupational therapy, east Asian medicine, massage therapy, and speech and hearing therapies that meet the standards of medical necessity and are subject to quantitative treatment limits of the health plan.

Summary of Bill: The bill as referred to committee not considered.

Summary of Bill (Proposed Substitute): Definitions. HCBMs are defined as any person or entity providing service to, or acting on behalf of, a health carrier, public employee benefit program, or 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- and pre-authorization;
- certification of benefits;
- medical necessity determinations;
- utilization review;
- benefit determinations;
- claims processing;
- provider credentialing;
- dispute Resolution; and
- provider network management.

HCBMs include persons acting as a laboratory benefit manager (LBM), PBM or RBM, but do not include health care service contractors, health maintenance organizations, or issuers.

LBM is defined as a person providing service to or acting on behalf of health carrier, public employee benefit program, or school employee benefit program, that dictates or limits health care provider decision making relating to the use of clinical laboratory services.

Critical access pharmacies are defined as a pharmacy in Washington outside a ten mile radius of another pharmacy, or within a ten mile radius of another pharmacy, but for which closure of either pharmacy could result in impaired access for a rural area.

Licensure. Any person acting in the capacity of a HCBM must obtain a license, issued by the commissioner. The person must note in their application, among other information, if they are doing business as a PBM, RBM or a HCBM other than a PBM or RBM. Applicants for licensure must also pay license fees.

Every licensee must retain a record of all transactions completed under the license for a period of at least seven years from the date of creation.

No person may obtain a HCBM license, if they operate as a LBM under contract with a health insurance carrier and have a financial interest in clinical laboratory providers within the health insurance carrier's network.

Contracts. HCBMs must maintain a written agreement describing the rights and responsibilities of any parties to a contract with the HCBM. Every HCBM must file with the commissioner every benefit management contract and contract amendment, and every contract and contract amendment between the licensee and any other person entered into directly or indirectly in support of the licensee contract, at least 30 days prior to use of the contract or amendment. The commissioner may withdraw approval of a contract or amendment at any time for cause. These contractual requirements do not apply to any contract or amendment between a HCBM and a Taft-Hartley or employer-sponsored self-funded health plan.

Contract compensation provisions are exempt from disclosure, unless a reasonable person would believe the provision encourages managers to deny, delay, or limit benefits.

Fiduciary Duty. An HCBM has a fiduciary duty to patients and beneficiaries to perform services in accordance with state and federal law. An HCBM may not penalize, require, or provide financial incentives to beneficiaries as an incentive to use a specific provider or pharmacy in which a carrier, program, or benefit manager has an ownership interest. The commissioner may adopt rules to create exceptions to this requirement, such as for staff model health maintenance organizations that depend upon patient use of owned facilities.

An HCBM may not deny a benefit or impose a cost or limitation upon a beneficiary for health care services, drugs, or supplies. No person may collect a debt for the delivery of health care services, drugs, or supplies from a patient if a denial, limitation, cost, or debt is attributable to a violation of this requirement.

Fiduciary duties and subsequent requirements do not apply to any services provided by a HCBM to or on behalf of a Taft-Hartley or employer-sponsored self-funded health plan.

Enforcement. If an HCBM violates any laws or regulations pertaining to the HCBM, the commissioner is permitted to:

- place on probation, suspend, revoke, or refuse a license;
- issue a cease and desist order;
- levy a fine of up to $5,000 per violation;
- require corrective action; and
- charge the HCBM, the contracting carrier, and the program, for the costs, fees, and other expenses incurred by the commissioner to conduct an investigation, hearing, or court proceeding.

Carriers, public employee benefit programs, and school employee benefit programs are responsible for the HCBM compliance with state regulations.

Treatment Visit Prior Authorization. A health carrier may not require prior authorization, or require a treatment visit to meet the standards of medical necessity, for initial evaluation and management visits and up to six consecutive treatment visits for new episodes of care of

chiropractic, physical therapy, occupational therapy, east Asian medicine, massage, or speech and hearing therapies. A determination from a primary care provider or chiropractor that a treatment visit is medically necessary is sufficient for accessing the initial six visits.

Pharmacy Benefit Managers. Provisions regulating the practice of PBMs are transferred to the regulation of HCBMs doing business as a PBM. These provisions include:

- regulation of formularies and drug lists;
- requiring the maintenance of a network pharmacy appeals process;
- requiring participation in audits; and
- prohibiting participation in an action of fraud against a pharmacy.

HCBMs acting as a PBM may not:

- cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive or misleading;
- charge a 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, unless approved by the commission;
- reimburse a pharmacy in the state an amount less than the amount the PBM reimburses an affiliate for providing the same pharmacy service; and
- deny, reduce, or recoup payment from a pharmacy for pharmacy services after adjudication of a claim unless the claim was fraudulent, the original claim was incorrect; or the pharmacy services were not properly rendered.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on February 11, 2019.

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: PRO: Insurers who do business in Washington are regulated by OIC. Insurance companies had been managing their own benefits, and were regulated by the OIC, which meant consumers had a place to go for their complaints and concerns to be heard. However, with unregulated HCBMs, there is no place for consumers to go with complaints about benefit management services. This bill would place regulation of HCBMs under the regulatory authority of the OIC, and give consumers a place to go. These benefit managers are impacting decisions that should be solely part of the physician patient relationship. If folks can receive care early, there will be less costs to the health care system. Benefit managers are preventing patients from accessing care, which has led to patients not being able to work. The doctors who are reviewing patient cases for benefit managers are not even the type of provider who would be providing the service being requested. Patients are okay paying for insurance, but expect to be able to access their benefits when they need them. Pre-authorization strategies have no clinical basis. Denials of care are based on changing definitions of medical necessity that lack transparency. Patients are also misinformed about the state of the benefit manager industry. PBMs are preventing patients from accessing necessary care. Unfortunately, PBMs are one step ahead of regulation, which

has led to the need for this bill. Patients are being required to pay much more than pharmacies are being reimbursed for their medications. PBMs are pocketing all of the money in the middle, and sometimes carving back money because pharmacies are not meeting arbitrary star ratings. Removing financial incentives related to where you fill a prescription is good for patients.

CON: There are concerns that this bill would prohibit PBMs from requiring accreditations beyond what is required by the Board of Pharmacy. However, the Board of Pharmacy does not have regulation over pharmacy accreditation in the state. Accreditation is required for certain pharmacies for purposes of patient quality. This bill will not create better outcomes for patients. The purpose of benefit managers is to empower the improvement of health care, to ensure the right care is delivered at the right time, in the right place. Benefit manager guidelines are available online, and the organizations are transparent. Benefit managers ensure that evidence based practice is happening.

OTHER: There is concern that section 5 includes provisions related to primary care providers, which should be removed.

Persons Testifying: PRO: Senator Christine Rolfes, Prime Sponsor; Brenden Ritzman; Dr. Austin McMillin, Washington State Chiropractic Association; Ben Boyle, Physical Therapy Association of Washington; Kari Vanderhowen, Duvall Family Drugs; Kirk Heinz, Kirk's Pharmacy; Mike Donohue, Bob's Pharmacy; Joe Greitz; Lonnie Johns-Brown, Office of Insurance Commissioner; Julie Akers, citizen; Jim Hedrick, Washington State Radiological Society.

CON: Laurie Borgerding Johnson, EviCore Innovative Solutions; Mark Tate, EviCore Innovative Solutions; LuGina Mendez-Harper, Prime Therapeutics; Meg Jones, Association of Washington Healthcare Plans.

OTHER: Patricia Seib, Washington Academy of Family Physicians.

Persons Signed In To Testify But Not Testifying: No one.