FINAL BILL REPORT
2SSB 5601

PARTIAL VETO
C 240 L 20
Synopsis as Enacted

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).

Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means
House Committee on Health Care & Wellness
House Committee on Appropriations

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 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.

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.

Summary: Definitions. Health care benefit managers (HCBMs) are defined as persons or entities providing services to or acting on behalf of, a health carrier, a public employee's benefits board program (PEBB), or a school employee's benefit board program (SEBB), that directly or indirectly impacts the determination or use of benefits for, or patient access to, health care services, drugs, and supplies including, but not limited to:

- prior- and pre-authorization;
- certification of benefits;
- medical necessity determinations;
- utilization review;
- benefit determinations;
- claims processing;
- outcome management;
- provider credentialing;
- payment or authorization of payment to providers and facilities;
- dispute resolution;
- provider network management; and
- disease management.

HCBMs include persons acting as a laboratory benefit manager, mental health benefit manager, PBM or RBM, but do not include health care service contractors, health maintenance organizations, issuers, discount health plan, direct patient-provider health plans, employer or union sponsored health plans, insurance producers, behavioral health administrative service organization, or a hospital or ambulatory surgical facility.

A PBM is a person that contracts with pharmacies on behalf of an insurer, third party payer, or the prescription drug purchasing consortium to:

- process claims;
- provide retail network management;
- pay pharmacies or pharmacists;
- negotiate rebates;
- manage pharmacy networks; or
- make credentialing determinations.

Registration. Any person acting in the capacity of a HCBM must obtain a registration, issued by the commissioner, and renew the registration annually. The person must note in their application, among other information, any areas of specialty. Applicants for registration must also pay license fees.

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

Contracts. HCBMs must maintain a written agreement describing the rights and responsibilities of any parties to a contract with the HCBM. A HCBM must file with the commissioner every benefit management contract and between the HCBM and a provider, pharmacy, pharmacy services administration organization, or another HCBM, that is entered into in support of a contract with a carrier, PEBB, or SEBB, within 30 days following the effective date of the contract or amendment.

Carriers must file all contracts and contract amendments entered into with a HCBM with the commissioner, within 30 days following the effective date of the contract. Carriers must notify enrollees in any health plan operated by the carrier of any HCBM providing benefit management services in support of the administration of the health plan.

Contracts filed with the commissioner are exempt from public disclosure.

Enforcement. If the commissioner notifies a carrier or HCBM about a filed inquiry or complaint that pertains to a HCBM, the commissioner must concurrently notify the HCBM and any carrier what the inquiry or complaint pertains to.

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 registration;
- issue a cease and desist order;
- levy a fine up to $5,000 per violation; and
- require corrective action.

Carriers, PEBB, and SEBB, are responsible for the HCBM compliance with state regulations.

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.

Separate registration requirements for PBMs are repealed. A PBM is considered a HCBM, and must be registered as a HCBM.

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, or for credentialing, participating, certification, accreditation, or enrollment in a network;
- require pharmacy accreditation standards or certification requirements inconsistent with or more stringent than standards required by national accreditation organizations;
- 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, or the denial or reduction was the result of a pharmacy audit.

Votes on Final Passage:

Senate	47	0	
House	97	0	(House amended)
Senate	47	0	(Senate concurred)

Effective: June 11, 2020
January 1, 2022 (Sections 1 through 19)

Partial Veto Summary: Removed the section establishing a work group on pharmacy contracts to review fee structures and the use of performance-based contracts.