# SENATE BILL REPORT
# 2SSB 5601

As Amended by House, March 6, 2020

**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 & Long Term Care: 2/18/19, 1/27/20, 2/03/20 [DPS-WM, w/oRec].
Ways & Means: 2/06/20, 2/10/20 [DP2S, w/oRec].
**Floor Activity:**
Passed Senate: 2/17/20, 47-0.
Passed House: 3/06/20, 97-0.

**Brief Summary of Second Substitute Bill**

- Requires anyone practicing as a health care benefit manager (HCBM) in Washington, including pharmacy benefit managers, to obtain a registration.
- Require HCBMs and carriers to file contracts with the office of the insurance commissioner.

## SENATE COMMITTEE ON HEALTH & LONG TERM CARE

**Majority Report**: That Substitute Senate Bill No. 5601 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Cleveland, Chair; Randall, Vice Chair; O'Ban, Ranking Member; Conway, Dhingra, Keiser and Van De Wege.

**Minority Report**: That it be referred without recommendation.

Signed by Senators Becker, Muzzall and Rivers.

**Staff**: Evan Klein (786-7483)

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*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.*

## SENATE COMMITTEE ON WAYS & MEANS

**Majority Report**: That Second Substitute Senate Bill No. 5601 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Rolfes, Chair; Frockt, Vice Chair, Operating, Capital Lead; Mullet, Capital Budget Cabinet; Brown, Assistant Ranking Member, Operating; Becker, Billig, Carlyle, Conway, Darneille, Dhingra, Hasegawa, Hunt, Keiser, Muzzall, Pedersen, Rivers, Van De Wege, Wagoner, Warnick and Wilson, L..

**Minority Report**: That it be referred without recommendation.

Signed by Senators Braun, Ranking Member; Honeyford, Assistant Ranking Member, Capital; Schoesler.

**Staff**: Sandy Stith (786-7710)

**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.

**Summary of Second Substitute Bill**: Definitions. HCBMs are defined as a person or entity 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 utilization 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.

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

- process claims;
- provider 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 a period of 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 that 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 of 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.

Work Group. A performance-based pharmacy contract work group is established. The work group must consist of representatives appointed by the Governor from:

- the prescription drug consortium;
- the pharmacy quality assurance commission;
- an association representative independent pharmacies;
- an association representing chain pharmacies;
- each health carrier offering at least one health plan in the commercial market in Washington;
- an association representing an association of health carriers;
- each health carrier offering at least one health plan to Medicaid enrollees in Washington;

- PEBB or SEBB;
- 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.

**Appropriation**: None.

**Fiscal Note**: Available.

**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 on Proposed Substitute (Regular Session 2019) (Health & Long Term Care)**: 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 (Health & Long Term Care)**: PRO: Senator Christine Rolfes, Prime Sponsor; Brenden Ritzman, citizen; 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 (Health & Long Term Care)**: No one.

**Staff Summary of Public Testimony on Proposed Substitute (Regular Session 2020) (Health & Long Term Care)**: *The committee recommended a different version of the bill than what was heard.* PRO: The health care system is a convoluted and amazing mess. This bill is consumer protection legislation. There is a major frustration that there is a lack of transparency about how claims are determined, how benefits are administered, and how payment for claims is made. Consumers do not currently understand how their benefits can be utilized. These entities may be putting the health of patients at risk. These benefit managers have direct control over our health care and our well-being. This is not a critique of the business model, but consumers need to know who is making the decisions and how to hold these entities accountable for the decisions they make. Benefit managers started out as an administrative function before evolving into entities that make significant health care decisions. Direct oversight of these companies by the insurance commissioner will help the state understand who owns who and how these benefit manager contracts effect consumers. A patient's treating provider is in the best position to know when a patient needs to receive care, not a benefit manager. The requirements in the bill have moved from licensure to registration. Registration still gives enforcement authority to a the Office of the Insurance Commissioner, but registration does not require some of the financial disclosures that licensure would. It is important to continue to retain the broad definition of health care benefit manager in the bill. The issue of intervening third-party payers has been in existence for years. Pharmacy benefit managers are making billions of dollars, while adding costs for patients. PBMs are requiring pharmacies to use drugs that increase their profits, even if at the expense of patient access. It would be best to require health care benefit managers to be licensed, as opposed to registered. PBMs have continually found loopholes and ways around the existing law. There is a desire for equity in how benefit managers are overseen in relation to provider contracts.

OTHER: Good work has gone into this bill over the last six weeks, and while this legislation is greatly improved, there are some concerns that remain about the bill. While some level of benefit manager oversight might be appropriate, it must be balanced. Registration, filing of contracts, and language stating that carriers are specifically responsible for benefit manager compliance with Washington laws is appropriate. However, the overly broad definition of benefit manager may loop in entities that are not intended. There are also some restrictions on PBMs that still need to be addressed. The hope is to find balance with this legislation. The type of contracts that benefit managers are required to file with OIC is too broad, and should just pertain to benefit manager contracts with providers and pharmacies. The other issue is that the legislation prohibits PBMs from accrediting pharmacies beyond the accreditation standards of the state. PBMs often accredit specialty pharmacies, due to concerns over patient safety.

**Persons Testifying (Health & Long Term Care)**: PRO: Senator Christine Rolfes, Prime Sponsor; Senator Shelly Short; Lori Grassi, Washington State Chiropractic Association; Melissa Johnson, Physical Therapy Association of Washington, Washington Speech-Language-Hearing Association; Ryan Oftebro, Kelly Ross Pharmacy; Andrew Heinz, Kirk's Pharmacy, Eatonville; Lonnie Johns-Brown, Office of the Insurance Commissioner.

OTHER: Christine Brewer, Association of Washington Healthcare Plans; Dr. LuGina Mendez-Harper, Prime Therapeutics.

**Persons Signed In To Testify But Not Testifying (Health & Long Term Care)**: No one.

**Staff Summary of Public Testimony on First Substitute (Ways & Means) (Regular Session 2020)**: *The committee recommended a different version of the bill than what was heard.* PRO: HCBMs are often out of state and not physicians or health care professionals. Decisions made by HCBMs are made with no transparency and there is no accountability for their decisions. The fiscal note is written to the original bill and we believe this will be reduced based on the more narrow version of the current bill. The depth of impact of HCBMs may be far greater than those entities that are currently regulated. This bill does not represent a new concept. However, over the last few months, this process has involved stakeholders. Previously, this involved licensure. Now this involves registration. The OIC would have the authority to take action against HCBMs. The OIC would be able to directly investigate HCBMs. This is a transparency and accountability bill that allows patients to get timely access to their benefits. Pharmacies are seeing a trend of PBMs classifying HIV drugs as specialty drugs and requiring patients to transfer to specialty pharmacies. This steers patients to the PBM's own mail order pharmacies. In order for community pharmacies to participate in these programs, they are required to go through accreditation processes with the PBM at great cost. This has resulted in loss of access to patients and increased costs. PBMs have required shifts to brand name drugs that have increased costs for patients. There is not a lot of difference between registration and licensure. The idea was brought up as part of the workgroup. The workgroup decided to keep a framework of accountability and oversight and the filing of certain contracts. The bill also allows the OIC to take some regulatory action. The main difference between licensure versus pure registration, like this bill, is that licensure usually has more required fiscal information from the entities being licensed.

OTHER: We would like to continue discussions of potential changes with stakeholders present. We look forward to a new fiscal note and are not sure it will go down. The policy in this bill reflects transparency and accountability.

**Persons Testifying (Ways & Means)**: PRO: Lonnie Johns-Brown, Office of the Insurance Commissioner; Melissa Johnson, Physical Therapy Association of Washington; Washington Speech-Language-Hearing Association; Lori Grassi, Washington State Chiropractic Association; Ryan Oftebro, Kelley-Ross Pharmacy.

OTHER: Christine Brewer, Association of Washington Healthcare Plans; Carrie Tellefson, Pharmaceutical Care Management Association.

**Persons Signed In To Testify But Not Testifying (Ways & Means)**: No one.

**EFFECT OF HOUSE AMENDMENT(S)**:

- Exempts employee benefits programs from the enforcement actions the commissioner is authorized to impose.
- Adds pharmacy fee structures in the delivery of pharmacy benefits to the subjects the work group must review and include in its final report.
- Changes the membership of the work group by:
    - removing the representative of a state agency that purchases health care services and drugs for a selected population;
    - removing the representative of a health carrier offering health plans to Medicaid enrollees;
    - adding a representative from the Office of the Insurance Commissioner'
    - adding a representative from each of the two largest caucuses of the House of Representatives and the Senate;
    - changing the composition of the pharmacy members to one representing all pharmacies and one representing hospital pharmacies, instead of one representing independent pharmacies and one representing chain pharmacies;
    - 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;
    - clarifying that the Public Employees' Benefits Board and the School Employees' Benefits Board be represented by the Health Care Authority; and
    - clarifying that the second Health Care Authority member represent the state Medicaid program.
- Delays the work group's final report until September 1, 2021, instead of December 1, 2020, and requires a progress report by January 1, 2021.
- Changes the effective date for the commissioner's rulemaking authority from July 1, 2021, to 90 days after the adjournment of the session in which the bill is passed.