
SECOND SUBSTITUTE SENATE BILL 5601

State of Washington

66th Legislature

2020 Regular Session

By Senate Ways & Means (originally sponsored by Senators Rolfes, Short, Keiser, Lias, Kuderer, Walsh, Hobbs, King, Warnick, Honeyford, and Conway)

READ FIRST TIME 02/11/20.

1 AN ACT Relating to health care benefit managers; amending RCW
2 48.02.120, 48.02.220, 42.56.400, 19.340.020, 19.340.040, 19.340.070,
3 19.340.080, 19.340.090, 19.340.100, and 19.340.110; adding a new
4 section to chapter 48.43 RCW; adding a new chapter to Title 48 RCW;
5 creating new sections; recodifying RCW 19.340.020, 19.340.040,
6 19.340.050, 19.340.060, 19.340.070, 19.340.080, 19.340.090,
7 19.340.100, and 19.340.110; repealing RCW 19.340.010, 19.340.030, and
8 19.365.010; prescribing penalties; and providing effective dates.

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

10 NEW SECTION. **Sec. 1.** (1) The legislature finds that growth in
11 managed health care systems has shifted substantial authority over
12 health care decisions from providers and patients to health carriers
13 and health care benefit managers. Health care benefit managers acting
14 as intermediaries between carriers, health care providers, and
15 patients exercise broad discretion to affect health care services
16 recommended and delivered by providers and the health care choices of
17 patients. Regularly, these health care benefit managers are making
18 health care decisions on behalf of carriers. However, unlike
19 carriers, health care benefit managers are not currently regulated.

1 (2) Therefore, the legislature finds that it is in the best
2 interest of the public to create a separate chapter in this title for
3 health care benefit managers.

4 (3) The legislature intends to protect and promote the health,
5 safety, and welfare of Washington residents by establishing standards
6 for regulatory oversight of health care benefit managers.

7 NEW SECTION. **Sec. 2.** The definitions in this section apply
8 throughout this chapter unless the context clearly requires
9 otherwise.

10 (1) "Affiliate" or "affiliated employer" means a person who
11 directly or indirectly through one or more intermediaries, controls
12 or is controlled by, or is under common control with, another
13 specified person.

14 (2) "Certification" has the same meaning as in RCW 48.43.005.

15 (3) "Employee benefits programs" means programs under both the
16 public employees' benefits board established in RCW 41.05.055 and the
17 school employees' benefits board established in RCW 41.05.740.

18 (4)(a) "Health care benefit manager" means a person or entity
19 providing services to, or acting on behalf of, a health carrier or
20 employee benefits programs, that directly or indirectly impacts the
21 determination or utilization of benefits for, or patient access to,
22 health care services, drugs, and supplies including, but not limited
23 to:

24 (i) Prior authorization or preauthorization of benefits or care;

25 (ii) Certification of benefits or care;

26 (iii) Medical necessity determinations;

27 (iv) Utilization review;

28 (v) Benefit determinations;

29 (vi) Claims processing and repricing for services and procedures;

30 (vii) Outcome management;

31 (viii) Provider credentialing and recredentialing;

32 (ix) Payment or authorization of payment to providers and
33 facilities for services or procedures;

34 (x) Dispute resolution, grievances, or appeals relating to
35 determinations or utilization of benefits;

36 (xi) Provider network management; or

37 (xii) Disease management.

38 (b) "Health care benefit manager" includes, but is not limited
39 to, health care benefit managers that specialize in specific types of

1 health care benefit management such as pharmacy benefit managers,
2 radiology benefit managers, laboratory benefit managers, and mental
3 health benefit managers.

4 (c) "Health care benefit manager" does not include:

5 (i) Health care service contractors as defined in RCW 48.44.010;

6 (ii) Health maintenance organizations as defined in RCW
7 48.46.020;

8 (iii) Issuers as defined in RCW 48.01.053;

9 (iv) The public employees' benefits board established in RCW
10 41.05.055;

11 (v) The school employees' benefits board established in RCW
12 41.05.740;

13 (vi) Discount plans as defined in RCW 48.155.010;

14 (vii) Direct patient-provider primary care practices as defined
15 in RCW 48.150.010;

16 (viii) An employer administering its employee benefit plan or the
17 employee benefit plan of an affiliated employer under common
18 management and control;

19 (ix) A union administering a benefit plan on behalf of its
20 members;

21 (x) An insurance producer selling insurance or engaged in related
22 activities within the scope of the producer's license;

23 (xi) A creditor acting on behalf of its debtors with respect to
24 insurance, covering a debt between the creditor and its debtors;

25 (xii) A behavioral health administrative services organization or
26 other county-managed entity that has been approved by the state
27 health care authority to perform delegated functions on behalf of a
28 carrier;

29 (xiii) A hospital licensed under chapter 70.41 RCW or ambulatory
30 surgical facility licensed under chapter 70.230 RCW;

31 (xiv) The Robert Bree collaborative under chapter 70.250 RCW;

32 (xv) The health technology clinical committee established under
33 RCW 70.14.090; or

34 (xvi) The prescription drug purchasing consortium established
35 under RCW 70.14.060.

36 (5) "Health care provider" or "provider" has the same meaning as
37 in RCW 48.43.005.

38 (6) "Health care service" has the same meaning as in RCW
39 48.43.005.

1 (7) "Health carrier" or "carrier" has the same meaning as in RCW
2 48.43.005.

3 (8) "Laboratory benefit manager" means a person or entity
4 providing service to, or acting on behalf of, a health carrier,
5 employee benefits programs, or another entity under contract with a
6 carrier, that directly or indirectly impacts the determination or
7 utilization of benefits for, or patient access to, health care
8 services, drugs, and supplies relating to the use of clinical
9 laboratory services and includes any requirement for a health care
10 provider to submit a notification of an order for such services.

11 (9) "Mental health benefit manager" means a person or entity
12 providing service to, or acting on behalf of, a health carrier,
13 employee benefits programs, or another entity under contract with a
14 carrier, that directly or indirectly impacts the determination of
15 utilization of benefits for, or patient access to, health care
16 services, drugs, and supplies relating to the use of mental health
17 services and includes any requirement for a health care provider to
18 submit a notification of an order for such services.

19 (10) "Network" means the group of participating providers,
20 pharmacies, and suppliers providing health care services, drugs, or
21 supplies to beneficiaries of a particular carrier or plan.

22 (11) "Person" includes, as applicable, natural persons, licensed
23 health care providers, carriers, corporations, companies, trusts,
24 unincorporated associations, and partnerships.

25 (12)(a) "Pharmacy benefit manager" means a person that contracts
26 with pharmacies on behalf of an insurer, a third-party payor, or the
27 prescription drug purchasing consortium established under RCW
28 70.14.060 to:

29 (i) Process claims for prescription drugs or medical supplies or
30 provide retail network management for pharmacies or pharmacists;

31 (ii) Pay pharmacies or pharmacists for prescription drugs or
32 medical supplies;

33 (iii) Negotiate rebates with manufacturers for drugs paid for or
34 procured as described in this subsection;

35 (iv) Manage pharmacy networks; or

36 (v) Make credentialing determinations.

37 (b) "Pharmacy benefit manager" does not include a health care
38 service contractor as defined in RCW 48.44.010.

39 (13)(a) "Radiology benefit manager" means any person or entity
40 providing service to, or acting on behalf of, a health carrier,

1 employee benefits programs, or another entity under contract with a
2 carrier, that directly or indirectly impacts the determination or
3 utilization of benefits for, or patient access to, the services of a
4 licensed radiologist or to advanced diagnostic imaging services
5 including, but not limited to:

6 (i) Processing claims for services and procedures performed by a
7 licensed radiologist or advanced diagnostic imaging service provider;
8 or

9 (ii) Providing payment or payment authorization to radiology
10 clinics, radiologists, or advanced diagnostic imaging service
11 providers for services or procedures.

12 (b) "Radiology benefit manager" does not include a health care
13 service contractor as defined in RCW 48.44.010, a health maintenance
14 organization as defined in RCW 48.46.020, or an issuer as defined in
15 RCW 48.01.053.

16 (14) "Utilization review" has the same meaning as in RCW
17 48.43.005.

18 NEW SECTION. **Sec. 3.** (1) To conduct business in this state, a
19 health care benefit manager must register with the commissioner and
20 annually renew the registration.

21 (2) To apply for registration under this section, a health care
22 benefit manager must:

23 (a) Submit an application on forms and in a manner prescribed by
24 the commissioner and verified by the applicant by affidavit or
25 declaration under chapter 5.50 RCW. Applications must contain at
26 least the following information:

27 (i) The identity of the health care benefit manager and of
28 persons with any ownership or controlling interest in the applicant
29 including relevant business licenses and tax identification numbers,
30 and the identity of any entity that the health care benefit manager
31 has a controlling interest in;

32 (ii) The business name, address, phone number, and contact person
33 for the health care benefit manager;

34 (iii) Any areas of specialty such as pharmacy benefit management,
35 radiology benefit management, laboratory benefit management, mental
36 health benefit management, or other specialty; and

37 (iv) Any other information as the commissioner may reasonably
38 require.

1 (b) Pay an initial registration fee and annual renewal
2 registration fee as established in rule by the commissioner. The fees
3 for each registration must be set by the commissioner in an amount
4 that ensures the registration, renewal, and oversight activities are
5 self-supporting. If one health care benefit manager has a contract
6 with more than one carrier, the health care benefit manager must
7 complete only one application providing the details necessary for
8 each contract.

9 (3) All receipts from fees collected by the commissioner under
10 this section must be deposited into the insurance commissioner's
11 regulatory account created in RCW 48.02.190.

12 (4) Before approving an application for or renewal of a
13 registration, the commissioner must find that the health care benefit
14 manager:

15 (a) Has not committed any act that would result in denial,
16 suspension, or revocation of a registration;

17 (b) Has paid the required fees; and

18 (c) Has the capacity to comply with, and has designated a person
19 responsible for, compliance with state and federal laws.

20 (5) Any material change in the information provided to obtain or
21 renew a registration must be filed with the commissioner within
22 thirty days of the change.

23 (6) Every registered health care benefit manager must retain a
24 record of all transactions completed for a period of not less than
25 seven years from the date of their creation. All such records as to
26 any particular transaction must be kept available and open to
27 inspection by the commissioner during the seven years after the date
28 of completion of such transaction.

29 NEW SECTION. **Sec. 4.** (1) A health care benefit manager may not
30 provide health care benefit management services to a health carrier
31 or employee benefits programs without a written agreement describing
32 the rights and responsibilities of the parties conforming to the
33 provisions of this chapter and any rules adopted by the commissioner
34 to implement or enforce this chapter including rules governing
35 contract content.

36 (2) A health care benefit manager must file with the commissioner
37 in the form and manner prescribed by the commissioner, every benefit
38 management contract and contract amendment between the health care
39 benefit manager and a provider, pharmacy, pharmacy services

1 administration organization, or other health care benefit manager,
2 entered into directly or indirectly in support of a contract with a
3 carrier or employee benefits programs, within thirty days following
4 the effective date of the contract or contract amendment.

5 (3) Contracts filed under this section are confidential and not
6 subject to public inspection under RCW 48.02.120(2), or public
7 disclosure under chapter 42.56 RCW, if filed in accordance with the
8 procedures for submitting confidential filings through the system for
9 electronic rate and form filings and the general filing instructions
10 as set forth by the commissioner. In the event the referenced filing
11 fails to comply with the filing instructions setting forth the
12 process to withhold the contract from public inspection, and the
13 health care benefit manager indicates that the contract is to be
14 withheld from public inspection, the commissioner must reject the
15 filing and notify the health care benefit manager through the system
16 for electronic rate and form filings to amend its filing to comply
17 with the confidentiality filing instructions.

18 NEW SECTION. **Sec. 5.** (1) Upon notifying a carrier or health
19 care benefit manager of an inquiry or complaint filed with the
20 commissioner pertaining to the conduct of a health care benefit
21 manager identified in the inquiry or complaint, the commissioner must
22 provide notice of the inquiry or complaint concurrently to the health
23 care benefit manager and any carrier to which the inquiry or
24 complaint pertains.

25 (2) Upon receipt of an inquiry from the commissioner, a health
26 care benefit manager must provide to the commissioner within fifteen
27 business days, in the form and manner required by the commissioner, a
28 complete response to that inquiry including, but not limited to,
29 providing a statement or testimony, producing its accounts, records,
30 and files, responding to complaints, or responding to surveys and
31 general requests. Failure to make a complete or timely response
32 constitutes a violation of this chapter.

33 (3) Subject to chapter 48.04 RCW, if the commissioner finds that
34 a health care benefit manager or any person responsible for the
35 conduct of the health care benefit manager's affairs has:

36 (a) Violated any insurance law, or violated any rule, subpoena,
37 or order of the commissioner or of another state's insurance
38 commissioner;

1 (b) Failed to renew the health care benefit manager's
2 registration;

3 (c) Failed to pay the registration or renewal fees;

4 (d) Provided incorrect, misleading, incomplete, or materially
5 untrue information to the commissioner, to a carrier, or to a
6 beneficiary;

7 (e) Used fraudulent, coercive, or dishonest practices, or
8 demonstrated incompetence, or financial irresponsibility in this
9 state or elsewhere; or

10 (f) Had a health care benefit manager registration, or its
11 equivalent, denied, suspended, or revoked in any other state,
12 province, district, or territory;

13 the commissioner may take any combination of the following actions:

14 (i) Place on probation, suspend, revoke, or refuse to issue or
15 renew the health care benefit manager's registration;

16 (ii) Issue a cease and desist order against the health care
17 benefit manager and contracting carrier;

18 (iii) Fine the health care benefit manager up to five thousand
19 dollars per violation, and the contracting carrier is subject to a
20 fine for acts conducted under the contract;

21 (iv) Issue an order requiring corrective action against the
22 health care benefit manager, the contracting carrier acting with the
23 health care benefit manager, or both the health care benefit manager
24 and the contracting carrier acting with the health care benefit
25 manager; and

26 (v) Temporarily suspend the health care benefit manager's
27 registration by an order served by mail or by personal service upon
28 the health care benefit manager not less than three days prior to the
29 suspension effective date. The order must contain a notice of
30 revocation and include a finding that the public safety or welfare
31 requires emergency action. A temporary suspension under this
32 subsection (3)(f)(v) continues until proceedings for revocation are
33 concluded.

34 (4) A stay of action is not available for actions the
35 commissioner takes by cease and desist order, by order on hearing, or
36 by temporary suspension.

37 (5)(a) Health carriers and employee benefits programs are
38 responsible for the compliance of any person or organization acting
39 directly or indirectly on behalf of or at the direction of the
40 carrier or program, or acting pursuant to carrier or program

1 standards or requirements concerning the coverage of, payment for, or
2 provision of health care benefits, services, drugs, and supplies.

3 (b) A carrier or program contracting with a health care benefit
4 manager is responsible for the health care benefit manager's
5 violations of this chapter, including a health care benefit manager's
6 failure to produce records requested or required by the commissioner.

7 (c) No carrier or program may offer as a defense to a violation
8 of any provision of this chapter that the violation arose from the
9 act or omission of a health care benefit manager, or other person
10 acting on behalf of or at the direction of the carrier or program,
11 rather than from the direct act or omission of the carrier or
12 program.

13 NEW SECTION. **Sec. 6.** A new section is added to chapter 48.43
14 RCW to read as follows:

15 (1) A carrier must file with the commissioner in the form and
16 manner prescribed by the commissioner every contract and contract
17 amendment between the carrier and any health care benefit manager
18 registered under section 3 of this act, within thirty days following
19 the effective date of the contract or contract amendment.

20 (2) For health plans issued or renewed on or after January 1,
21 2022, carriers must notify health plan enrollees in writing of each
22 health care benefit manager contracted with the carrier to provide
23 any benefit management services in the administration of the health
24 plan.

25 (3) Contracts filed under this section are confidential and not
26 subject to public inspection under RCW 48.02.120(2), or public
27 disclosure under chapter 42.56 RCW, if filed in accordance with the
28 procedures for submitting confidential filings through the system for
29 electronic rate and form filings and the general filing instructions
30 as set forth by the commissioner. In the event the referenced filing
31 fails to comply with the filing instructions setting forth the
32 process to withhold the contract from public inspection, and the
33 carrier indicates that the contract is to be withheld from public
34 inspection, the commissioner must reject the filing and notify the
35 carrier through the system for electronic rate and form filings to
36 amend its filing to comply with the confidentiality filing
37 instructions.

38 (4) For purposes of this section, "health care benefit manager"
39 has the same meaning as in section 2 of this act.

1 **Sec. 7.** RCW 48.02.120 and 2011 c 312 s 1 are each amended to
2 read as follows:

3 (1) The commissioner shall preserve in permanent form records of
4 his or her proceedings, hearings, investigations, and examinations,
5 and shall file such records in his or her office.

6 (2) The records of the commissioner and insurance filings in his
7 or her office shall be open to public inspection, except as otherwise
8 provided by sections 4 and 6 of this act and this code.

9 (3) Except as provided in subsection (4) of this section,
10 actuarial formulas, statistics, and assumptions submitted in support
11 of a rate or form filing by an insurer, health care service
12 contractor, or health maintenance organization or submitted to the
13 commissioner upon his or her request shall be withheld from public
14 inspection in order to preserve trade secrets or prevent unfair
15 competition.

16 (4) For individual and small group health benefit plan rate
17 filings submitted on or after July 1, 2011, subsection (3) of this
18 section applies only to the numeric values of each small group rating
19 factor used by a health carrier as authorized by RCW 48.21.045(3)(a),
20 48.44.023(3)(a), and 48.46.066(3)(a). Subsection (3) of this section
21 may continue to apply for a period of one year from the date a new
22 individual or small group product filing is submitted or until the
23 next rate filing for the product, whichever occurs earlier, if the
24 commissioner determines that the proposed rate filing is for a new
25 product that is distinct and unique from any of the carrier's
26 currently or previously offered health benefit plans. Carriers must
27 make a written request for a product classification as a new product
28 under this subsection and must receive subsequent written approval by
29 the commissioner for this subsection to apply.

30 (5) Unless the commissioner has determined that a filing is for a
31 new product pursuant to subsection (4) of this section, for all
32 individual or small group health benefit rate filings submitted on or
33 after July 1, 2011, the health carrier must submit part I rate
34 increase summary and part II written explanation of the rate increase
35 as set forth by the department of health and human services at the
36 time of filing, and the commissioner must:

37 (a) Make each filing and the part I rate increase summary and
38 part II written explanation of the rate increase available for public
39 inspection on the tenth calendar day after the commissioner

1 determines that the rate filing is complete and accepts the filing
2 for review through the electronic rate and form filing system; and

3 (b) Prepare a standardized rate summary form, to explain his or
4 her findings after the rate review process is completed. The
5 commissioner's summary form must be included as part of the rate
6 filing documentation and available to the public electronically.

7 **Sec. 8.** RCW 48.02.220 and 2016 c 210 s 5 are each amended to
8 read as follows:

9 (1) The commissioner shall accept registration of ((~~pharmacy~~))
10 health care benefit managers as established in ((~~RCW 19.340.030~~))
11 section 3 of this act and receipts shall be deposited in the
12 insurance commissioner's regulatory account.

13 (2) The commissioner shall have enforcement authority over
14 chapter ((~~19.340~~)) 48.--- RCW (the new chapter created in section 17
15 of this act) consistent with requirements established in RCW
16 19.340.110 (as recodified by this act).

17 (3) The commissioner may adopt rules to implement chapter
18 ((~~19.340~~)) 48.--- RCW (the new chapter created in section 17 of this
19 act) and to establish registration and renewal fees that ensure the
20 registration, renewal, and oversight activities are self-supporting.

21 **Sec. 9.** RCW 42.56.400 and 2019 c 389 s 102 are each amended to
22 read as follows:

23 The following information relating to insurance and financial
24 institutions is exempt from disclosure under this chapter:

25 (1) Records maintained by the board of industrial insurance
26 appeals that are related to appeals of crime victims' compensation
27 claims filed with the board under RCW 7.68.110;

28 (2) Information obtained and exempted or withheld from public
29 inspection by the health care authority under RCW 41.05.026, whether
30 retained by the authority, transferred to another state purchased
31 health care program by the authority, or transferred by the authority
32 to a technical review committee created to facilitate the
33 development, acquisition, or implementation of state purchased health
34 care under chapter 41.05 RCW;

35 (3) The names and individual identification data of either all
36 owners or all insureds, or both, received by the insurance
37 commissioner under chapter 48.102 RCW;

38 (4) Information provided under RCW 48.30A.045 through 48.30A.060;

1 (5) Information provided under RCW 48.05.510 through 48.05.535,
2 48.43.200 through 48.43.225, 48.44.530 through 48.44.555, and
3 48.46.600 through 48.46.625;

4 (6) Examination reports and information obtained by the
5 department of financial institutions from banks under RCW 30A.04.075,
6 from savings banks under RCW 32.04.220, from savings and loan
7 associations under RCW 33.04.110, from credit unions under RCW
8 31.12.565, from check cashers and sellers under RCW 31.45.030(3), and
9 from securities brokers and investment advisers under RCW 21.20.100,
10 all of which is confidential and privileged information;

11 (7) Information provided to the insurance commissioner under RCW
12 48.110.040(3);

13 (8) Documents, materials, or information obtained by the
14 insurance commissioner under RCW 48.02.065, all of which are
15 confidential and privileged;

16 (9) Documents, materials, or information obtained by the
17 insurance commissioner under RCW 48.31B.015(2) (l) and (m),
18 48.31B.025, 48.31B.030, and 48.31B.035, all of which are confidential
19 and privileged;

20 (10) Data filed under RCW 48.140.020, 48.140.030, 48.140.050, and
21 7.70.140 that, alone or in combination with any other data, may
22 reveal the identity of a claimant, health care provider, health care
23 facility, insuring entity, or self-insurer involved in a particular
24 claim or a collection of claims. For the purposes of this subsection:

25 (a) "Claimant" has the same meaning as in RCW 48.140.010(2).

26 (b) "Health care facility" has the same meaning as in RCW
27 48.140.010(6).

28 (c) "Health care provider" has the same meaning as in RCW
29 48.140.010(7).

30 (d) "Insuring entity" has the same meaning as in RCW
31 48.140.010(8).

32 (e) "Self-insurer" has the same meaning as in RCW 48.140.010(11);

33 (11) Documents, materials, or information obtained by the
34 insurance commissioner under RCW 48.135.060;

35 (12) Documents, materials, or information obtained by the
36 insurance commissioner under RCW 48.37.060;

37 (13) Confidential and privileged documents obtained or produced
38 by the insurance commissioner and identified in RCW 48.37.080;

39 (14) Documents, materials, or information obtained by the
40 insurance commissioner under RCW 48.37.140;

- 1 (15) Documents, materials, or information obtained by the
2 insurance commissioner under RCW 48.17.595;
- 3 (16) Documents, materials, or information obtained by the
4 insurance commissioner under RCW 48.102.051(1) and 48.102.140 (3) and
5 (7) (a) (ii);
- 6 (17) Documents, materials, or information obtained by the
7 insurance commissioner in the commissioner's capacity as receiver
8 under RCW 48.31.025 and 48.99.017, which are records under the
9 jurisdiction and control of the receivership court. The commissioner
10 is not required to search for, log, produce, or otherwise comply with
11 the public records act for any records that the commissioner obtains
12 under chapters 48.31 and 48.99 RCW in the commissioner's capacity as
13 a receiver, except as directed by the receivership court;
- 14 (18) Documents, materials, or information obtained by the
15 insurance commissioner under RCW 48.13.151;
- 16 (19) Data, information, and documents provided by a carrier
17 pursuant to section 1, chapter 172, Laws of 2010;
- 18 (20) Information in a filing of usage-based insurance about the
19 usage-based component of the rate pursuant to RCW 48.19.040(5) (b);
- 20 (21) Data, information, and documents, other than those described
21 in RCW 48.02.210(2) as it existed prior to repeal by section 2,
22 chapter 7, Laws of 2017 3rd sp. sess., that are submitted to the
23 office of the insurance commissioner by an entity providing health
24 care coverage pursuant to RCW 28A.400.275 as it existed on January 1,
25 2017, and RCW 48.02.210 as it existed prior to repeal by section 2,
26 chapter 7, Laws of 2017 3rd sp. sess.;
- 27 (22) Data, information, and documents obtained by the insurance
28 commissioner under RCW 48.29.017;
- 29 (23) Information not subject to public inspection or public
30 disclosure under RCW 48.43.730(5);
- 31 (24) Documents, materials, or information obtained by the
32 insurance commissioner under chapter 48.05A RCW;
- 33 (25) Documents, materials, or information obtained by the
34 insurance commissioner under RCW 48.74.025, 48.74.028, 48.74.100(6),
35 48.74.110(2) (b) and (c), and 48.74.120 to the extent such documents,
36 materials, or information independently qualify for exemption from
37 disclosure as documents, materials, or information in possession of
38 the commissioner pursuant to a financial conduct examination and
39 exempt from disclosure under RCW 48.02.065;

1 (26) Nonpublic personal health information obtained by, disclosed
2 to, or in the custody of the insurance commissioner, as provided in
3 RCW 48.02.068;

4 (27) Data, information, and documents obtained by the insurance
5 commissioner under RCW 48.02.230;

6 (28) Documents, materials, or other information, including the
7 corporate annual disclosure obtained by the insurance commissioner
8 under RCW 48.195.020;

9 (29) Findings and orders disapproving acquisition of a trust
10 institution under RCW 30B.53.100(3); ~~((and))~~

11 (30) All claims data, including health care and financial related
12 data received under RCW 41.05.890, received and held by the health
13 care authority; and

14 (31) Contracts not subject to public disclosure under sections 4
15 and 6 of this act.

16 **Sec. 10.** RCW 19.340.020 and 2014 c 213 s 3 are each amended to
17 read as follows:

18 ~~((As used in))~~ The definitions in this section apply throughout
19 this section and RCW 19.340.040 through ~~((19.340.090:))~~ 19.340.110
20 (as recodified by this act) unless the context clearly requires
21 otherwise.

22 (1) "Audit" means an on-site or remote review of the records of a
23 pharmacy by or on behalf of an entity.

24 (2) "Claim" means a request from a pharmacy or pharmacist to be
25 reimbursed for the cost of filling or refilling a prescription for a
26 drug or for providing a medical supply or service.

27 (3) "Clerical error" means a minor error:

28 (a) In the keeping, recording, or transcribing of records or
29 documents or in the handling of electronic or hard copies of
30 correspondence;

31 (b) That does not result in financial harm to an entity; and

32 (c) That does not involve dispensing an incorrect dose, amount,
33 or type of medication, or dispensing a prescription drug to the wrong
34 person.

35 ~~((3))~~ (4) "Entity" includes:

36 (a) A pharmacy benefit manager;

37 (b) An insurer;

38 (c) A third-party payor;

39 (d) A state agency; or

1 (e) A person that represents or is employed by one of the
2 entities described in this subsection.

3 ~~((4))~~ (5) "Fraud" means knowingly and willfully executing or
4 attempting to execute a scheme, in connection with the delivery of or
5 payment for health care benefits, items, or services, that uses false
6 or misleading pretenses, representations, or promises to obtain any
7 money or property owned by or under the custody or control of any
8 person.

9 (6) "Pharmacist" has the same meaning as in RCW 18.64.011.

10 (7) "Pharmacy" has the same meaning as in RCW 18.64.011.

11 (8) "Third-party payor" means a person licensed under RCW
12 48.39.005.

13 **Sec. 11.** RCW 19.340.040 and 2014 c 213 s 4 are each amended to
14 read as follows:

15 An entity that audits claims or an independent third party that
16 contracts with an entity to audit claims:

17 (1) Must establish, in writing, a procedure for a pharmacy to
18 appeal the entity's findings with respect to a claim and must provide
19 a pharmacy with a notice regarding the procedure, in writing or
20 electronically, prior to conducting an audit of the pharmacy's
21 claims;

22 (2) May not conduct an audit of a claim more than twenty-four
23 months after the date the claim was adjudicated by the entity;

24 (3) Must give at least fifteen days' advance written notice of an
25 on-site audit to the pharmacy or corporate headquarters of the
26 pharmacy;

27 (4) May not conduct an on-site audit during the first five days
28 of any month without the pharmacy's consent;

29 (5) Must conduct the audit in consultation with a pharmacist who
30 is licensed by this or another state if the audit involves clinical
31 or professional judgment;

32 (6) May not conduct an on-site audit of more than two hundred
33 fifty unique prescriptions of a pharmacy in any twelve-month period
34 except in cases of alleged fraud;

35 (7) May not conduct more than one on-site audit of a pharmacy in
36 any twelve-month period;

37 (8) Must audit each pharmacy under the same standards and
38 parameters that the entity uses to audit other similarly situated
39 pharmacies;

1 (9) Must pay any outstanding claims of a pharmacy no more than
2 forty-five days after the earlier of the date all appeals are
3 concluded or the date a final report is issued under RCW
4 19.340.080(3) (as recodified by this act);

5 (10) May not include dispensing fees or interest in the amount of
6 any overpayment assessed on a claim unless the overpaid claim was for
7 a prescription that was not filled correctly;

8 (11) May not recoup costs associated with:

9 (a) Clerical errors; or

10 (b) Other errors that do not result in financial harm to the
11 entity or a consumer; and

12 (12) May not charge a pharmacy for a denied or disputed claim
13 until the audit and the appeals procedure established under
14 subsection (1) of this section are final.

15 **Sec. 12.** RCW 19.340.070 and 2014 c 213 s 7 are each amended to
16 read as follows:

17 For purposes of RCW 19.340.020 and 19.340.040 through 19.340.090
18 (as recodified by this act), an entity, or an independent third party
19 that contracts with an entity to conduct audits, must allow as
20 evidence of validation of a claim:

21 (1) An electronic or physical copy of a valid prescription if the
22 prescribed drug was, within fourteen days of the dispensing date:

23 (a) Picked up by the patient or the patient's designee;

24 (b) Delivered by the pharmacy to the patient; or

25 (c) Sent by the pharmacy to the patient using the United States
26 postal service or other common carrier;

27 (2) Point of sale electronic register data showing purchase of
28 the prescribed drug, medical supply, or service by the patient or the
29 patient's designee; or

30 (3) Electronic records, including electronic beneficiary
31 signature logs, electronically scanned and stored patient records
32 maintained at or accessible to the audited pharmacy's central
33 operations, and any other reasonably clear and accurate electronic
34 documentation that corresponds to a claim.

35 **Sec. 13.** RCW 19.340.080 and 2014 c 213 s 8 are each amended to
36 read as follows:

37 (1)(a) After conducting an audit, an entity must provide the
38 pharmacy that is the subject of the audit with a preliminary report

1 of the audit. The preliminary report must be received by the pharmacy
2 no later than forty-five days after the date on which the audit was
3 completed and must be sent:

- 4 (i) By mail or common carrier with a return receipt requested; or
- 5 (ii) Electronically with electronic receipt confirmation.

6 (b) An entity shall provide a pharmacy receiving a preliminary
7 report under this subsection no fewer than forty-five days after
8 receiving the report to contest the report or any findings in the
9 report in accordance with the appeals procedure established under RCW
10 19.340.040(1) (as recodified by this act) and ~~((to provide))~~ must
11 allow the submission of additional documentation in support of the
12 claim. The entity shall consider a reasonable request for an
13 extension of time to submit documentation to contest the report or
14 any findings in the report.

15 (2) If an audit results in the dispute or denial of a claim, the
16 entity conducting the audit shall allow the pharmacy to resubmit the
17 claim using any commercially reasonable method, including facsimile,
18 mail, or ~~((electronic mail))~~ email.

19 (3) An entity must provide a pharmacy that is the subject of an
20 audit with a final report of the audit no later than sixty days after
21 the later of the date the preliminary report was received or the date
22 the pharmacy contested the report using the appeals procedure
23 established under RCW 19.340.040(1) (as recodified by this act). The
24 final report must include a final accounting of all moneys to be
25 recovered by the entity.

26 (4) Recoupment of disputed funds from a pharmacy by an entity or
27 repayment of funds to an entity by a pharmacy, unless otherwise
28 agreed to by the entity and the pharmacy, shall occur after the audit
29 and the appeals procedure established under RCW 19.340.040(1) (as
30 recodified by this act) are final. If the identified discrepancy for
31 an individual audit exceeds forty thousand dollars, any future
32 payments to the pharmacy may be withheld by the entity until the
33 audit and the appeals procedure established under RCW 19.340.040(1)
34 (as recodified by this act) are final.

35 **Sec. 14.** RCW 19.340.090 and 2014 c 213 s 9 are each amended to
36 read as follows:

37 RCW 19.340.020 and 19.340.040 through 19.340.090 (as recodified
38 by this act) do not:

1 (1) Preclude an entity from instituting an action for fraud
2 against a pharmacy;

3 (2) Apply to an audit of pharmacy records when fraud or other
4 intentional and willful misrepresentation is indicated by physical
5 review, review of claims data or statements, or other investigative
6 methods; or

7 (3) Apply to a state agency that is conducting audits or a person
8 that has contracted with a state agency to conduct audits of pharmacy
9 records for prescription drugs paid for by the state medical
10 assistance program.

11 **Sec. 15.** RCW 19.340.100 and 2016 c 210 s 4 are each amended to
12 read as follows:

13 (1) (~~(As used in this section:)~~) The definitions in this
14 subsection apply throughout this section unless the context clearly
15 requires otherwise.

16 (a) "List" means the list of drugs for which predetermined
17 reimbursement costs have been established, such as a maximum
18 allowable cost or maximum allowable cost list or any other benchmark
19 prices utilized by the pharmacy benefit manager and must include the
20 basis of the methodology and sources utilized to determine
21 multisource generic drug reimbursement amounts.

22 (b) "Multiple source drug" means a therapeutically equivalent
23 drug that is available from at least two manufacturers.

24 (c) "Multisource generic drug" means any covered outpatient
25 prescription drug for which there is at least one other drug product
26 that is rated as therapeutically equivalent under the food and drug
27 administration's most recent publication of "Approved Drug Products
28 with Therapeutic Equivalence Evaluations;" is pharmaceutically
29 equivalent or bioequivalent, as determined by the food and drug
30 administration; and is sold or marketed in the state during the
31 period.

32 (d) "Network pharmacy" means a retail drug outlet licensed as a
33 pharmacy under RCW 18.64.043 that contracts with a pharmacy benefit
34 manager.

35 (e) "Therapeutically equivalent" has the same meaning as in RCW
36 69.41.110.

37 (2) A pharmacy benefit manager:

38 (a) May not place a drug on a list unless there are at least two
39 therapeutically equivalent multiple source drugs, or at least one

1 generic drug available from only one manufacturer, generally
2 available for purchase by network pharmacies from national or
3 regional wholesalers;

4 (b) Shall ensure that all drugs on a list are readily available
5 for purchase by pharmacies in this state from national or regional
6 wholesalers that serve pharmacies in Washington;

7 (c) Shall ensure that all drugs on a list are not obsolete;

8 (d) Shall make available to each network pharmacy at the
9 beginning of the term of a contract, and upon renewal of a contract,
10 the sources utilized to determine the predetermined reimbursement
11 costs for multisource generic drugs of the pharmacy benefit manager;

12 (e) Shall make a list available to a network pharmacy upon
13 request in a format that is readily accessible to and usable by the
14 network pharmacy;

15 (f) Shall update each list maintained by the pharmacy benefit
16 manager every seven business days and make the updated lists,
17 including all changes in the price of drugs, available to network
18 pharmacies in a readily accessible and usable format;

19 (g) Shall ensure that dispensing fees are not included in the
20 calculation of the predetermined reimbursement costs for multisource
21 generic drugs;

22 (h) May not cause or knowingly permit the use of any
23 advertisement, promotion, solicitation, representation, proposal, or
24 offer that is untrue, deceptive, or misleading;

25 (i) May not charge a pharmacy a fee related to the adjudication
26 of a claim, credentialing, participation, certification,
27 accreditation, or enrollment in a network including, but not limited
28 to, a fee for the receipt and processing of a pharmacy claim, for the
29 development or management of claims processing services in a pharmacy
30 benefit manager network, or for participating in a pharmacy benefit
31 manager network;

32 (j) May not require accreditation standards inconsistent with or
33 more stringent than accreditation standards established by a national
34 accreditation organization;

35 (k) May not reimburse a pharmacy in the state an amount less than
36 the amount the pharmacy benefit manager reimburses an affiliate for
37 providing the same pharmacy services; and

38 (l) May not directly or indirectly retroactively deny or reduce a
39 claim or aggregate of claims after the claim or aggregate of claims
40 has been adjudicated, unless:

1 (i) The original claim was submitted fraudulently; or

2 (ii) The denial or reduction is the result of a pharmacy audit
3 conducted in accordance with RCW 19.340.040 (as recodified by this
4 act).

5 (3) A pharmacy benefit manager must establish a process by which
6 a network pharmacy may appeal its reimbursement for a drug subject to
7 predetermined reimbursement costs for multisource generic drugs. A
8 network pharmacy may appeal a predetermined reimbursement cost for a
9 multisource generic drug if the reimbursement for the drug is less
10 than the net amount that the network pharmacy paid to the supplier of
11 the drug. An appeal requested under this section must be completed
12 within thirty calendar days of the pharmacy submitting the appeal. If
13 after thirty days the network pharmacy has not received the decision
14 on the appeal from the pharmacy benefit manager, then the appeal is
15 considered denied.

16 The pharmacy benefit manager shall uphold the appeal of a
17 pharmacy with fewer than fifteen retail outlets, within the state of
18 Washington, under its corporate umbrella if the pharmacy or
19 pharmacist can demonstrate that it is unable to purchase a
20 therapeutically equivalent interchangeable product from a supplier
21 doing business in Washington at the pharmacy benefit manager's list
22 price.

23 (4) A pharmacy benefit manager must provide as part of the
24 appeals process established under subsection (3) of this section:

25 (a) A telephone number at which a network pharmacy may contact
26 the pharmacy benefit manager and speak with an individual who is
27 responsible for processing appeals; and

28 (b) If the appeal is denied, the reason for the denial and the
29 national drug code of a drug that has been purchased by other network
30 pharmacies located in Washington at a price that is equal to or less
31 than the predetermined reimbursement cost for the multisource generic
32 drug. A pharmacy with fifteen or more retail outlets, within the
33 state of Washington, under its corporate umbrella may submit
34 information to the commissioner about an appeal under subsection (3)
35 of this section for purposes of information collection and analysis.

36 (5)(a) If an appeal is upheld under this section, the pharmacy
37 benefit manager shall make a reasonable adjustment on a date no later
38 than one day after the date of determination.

39 (b) If the request for an adjustment has come from a critical
40 access pharmacy, as defined by the state health care authority by

1 rule for purposes related to the prescription drug purchasing
2 consortium established under RCW 70.14.060, the adjustment approved
3 under (a) of this subsection shall apply only to critical access
4 pharmacies.

5 (6) Beginning July 1, 2017, if a network pharmacy appeal to the
6 pharmacy benefit manager is denied, or if the network pharmacy is
7 unsatisfied with the outcome of the appeal, the pharmacy or
8 pharmacist may dispute the decision and request review by the
9 commissioner within thirty calendar days of receiving the decision.

10 (a) All relevant information from the parties may be presented to
11 the commissioner, and the commissioner may enter an order directing
12 the pharmacy benefit manager to make an adjustment to the disputed
13 claim, deny the pharmacy appeal, or take other actions deemed fair
14 and equitable. An appeal requested under this section must be
15 completed within thirty calendar days of the request.

16 (b) Upon resolution of the dispute, the commissioner shall
17 provide a copy of the decision to both parties within seven calendar
18 days.

19 (c) The commissioner may authorize the office of administrative
20 hearings, as provided in chapter 34.12 RCW, to conduct appeals under
21 this subsection (6).

22 (d) A pharmacy benefit manager may not retaliate against a
23 pharmacy for pursuing an appeal under this subsection (6).

24 (e) This subsection (6) applies only to a pharmacy with fewer
25 than fifteen retail outlets, within the state of Washington, under
26 its corporate umbrella.

27 (7) This section does not apply to the state medical assistance
28 program.

29 ~~((8) A pharmacy benefit manager shall comply with any requests
30 for information from the commissioner for purposes of the study of
31 the pharmacy chain of supply conducted under section 7, chapter 210,
32 Laws of 2016.))~~

33 **Sec. 16.** RCW 19.340.110 and 2016 c 210 s 2 are each amended to
34 read as follows:

35 (1) The commissioner shall have enforcement authority over this
36 chapter and shall have authority to render a binding decision in any
37 dispute between a pharmacy benefit manager, or third-party
38 administrator of prescription drug benefits, and a pharmacy arising

1 out of an appeal under RCW 19.340.100(6) (as recodified by this act)
2 regarding drug pricing and reimbursement.

3 (2) Any person, corporation, third-party administrator of
4 prescription drug benefits, pharmacy benefit manager, or business
5 entity which violates any provision of this chapter shall be subject
6 to a civil penalty in the amount of one thousand dollars for each act
7 in violation of this chapter or, if the violation was knowing and
8 willful, a civil penalty of five thousand dollars for each violation
9 of this chapter.

10 NEW SECTION. **Sec. 17.** Sections 1 through 5 of this act
11 constitute a new chapter in Title 48 RCW.

12 NEW SECTION. **Sec. 18.** RCW 19.340.020, 19.340.040, 19.340.050,
13 19.340.060, 19.340.070, 19.340.080, 19.340.090, 19.340.100, and
14 19.340.110 are each recodified as sections under a subchapter in
15 chapter 48.--- RCW (the new chapter created in section 17 of this
16 act).

17 NEW SECTION. **Sec. 19.** The following acts or parts of acts are
18 each repealed:

19 (1) RCW 19.340.010 (Definitions) and 2016 c 210 s 3 & 2014 c 213
20 s 1;

21 (2) RCW 19.340.030 (Pharmacy benefit managers—Registration—
22 Renewal) and 2016 c 210 s 1 & 2014 c 213 s 2; and

23 (3) RCW 19.365.010 (Registration required—Requirements) and 2015
24 c 166 s 1.

25 NEW SECTION. **Sec. 20.** The insurance commissioner may adopt any
26 rules necessary to implement this act.

27 NEW SECTION. **Sec. 21.** (1) Subject to the availability of
28 amounts appropriated for this specific purpose, the performance-based
29 pharmacy contract work group is established. The work group
30 membership must consist of the following members appointed by the
31 governor:

32 (a) A representative from the prescription drug purchasing
33 consortium described in RCW 70.14.060;

34 (b) A representative from the pharmacy quality assurance
35 commission;

1 (c) A representative from an association representing independent
2 pharmacies;

3 (d) A representative from an association representing chain
4 pharmacies;

5 (e) A representative from each health carrier offering at least
6 one health plan in a commercial market in the state;

7 (f) A representative from each health carrier offering at least
8 one health plan to medicaid enrollees in the state;

9 (g) A representative from an association representing health
10 carriers;

11 (h) A representative from the public employees' benefits board or
12 the school employees' benefits board;

13 (i) A representative from the health care authority;

14 (j) A representative from a pharmacy benefit manager; and

15 (k) A representative from a state agency that purchases health
16 care services and drugs for a selected population.

17 (2) The work group shall review the use of performance-based
18 contracts in the delivery of pharmacy benefits and develop
19 recommendations on designs and use of performance-based contracts.

20 (3) Staff support for the work group shall be provided by the
21 office of the insurance commissioner.

22 (4) By December 1, 2020, the work group shall submit a report to
23 the governor and the legislature detailing the current use of
24 performance-based contracts in the delivery of pharmacy benefits and
25 any recommendations for designs or use of performance-based contracts
26 in the delivery of pharmacy benefits. The report must include any
27 statutory changes necessary to implement the recommendations.

28 NEW SECTION. **Sec. 22.** If any provision of this act or its
29 application to any person or circumstance is held invalid, the
30 remainder of the act or the application of the provision to other
31 persons or circumstances is not affected.

32 NEW SECTION. **Sec. 23.** (1) Sections 1 through 19 of this act
33 take effect January 1, 2022.

34 (2) Section 20 of this act takes effect July 1, 2021.

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