SHB 1813 - H AMD **956**
By Representative Schmick

ADOPTED 02/11/2022

1 Strike everything after the enacting clause and insert the
2 following:

3 "NEW SECTION. **Sec. 1.** A new section is added to chapter 48.200
4 RCW to read as follows:
5 (1) A pharmacy benefit manager that administers a prescription
6 drug benefit may not:
7 (a) Require a covered person to use a mail order pharmacy;
8 (b) Require a covered person to obtain prescriptions from a mail
9 order pharmacy unless the prescription drug is a specialty or limited
10 distribution prescription drug; or
11 (c) Reimburse a covered person's chosen participating pharmacy an
12 amount less than the amount the pharmacy benefit manager reimburses
13 participating affiliated pharmacies.
14 (2) A pharmacy benefit manager shall:
15 (a) Include a provision in contracts with participating
16 pharmacies and pharmacy services administrative organizations that
17 authorizes the pharmacy to decline to fill a prescription if the
18 pharmacy benefit manager refuses to reimburse the pharmacy at a rate
19 that is at least equal to the pharmacy's acquisition cost of the
20 drug;
21 (b) Maintain an adequate and accessible pharmacy network for the
22 provision of prescription drugs for a health benefit plan. The
23 pharmacy network must provide for convenient access for covered
24 persons to pharmacies and critical access pharmacies;
25 (c) Regardless of the participating pharmacy, including mail
26 order pharmacies, where the covered person obtains the prescription
27 drug, apply the same copays, fees, days allowance, and other
28 conditions upon the enrollee; and
29 (d) Permit the covered person to receive delivery or mail order
30 of a medication through any participating pharmacy.
31 (3) If a covered person is using a mail order pharmacy, the
32 pharmacy benefit manager must:

(a) Allow for dispensing at local participating pharmacies under the following circumstances to ensure patient access to prescription drugs:

(i) If there are delays in mail order;

(ii) If the prescription drug arrives in an unusable condition; or

(iii) If the prescription drug does not arrive; and

(b) Ensure patients have easy and timely access to prescription counseling by a pharmacist.

(4) Subsection (1)(a) of this section does not apply to a health maintenance organization that is an integrated delivery system in which covered persons primarily use pharmacies that are owned and operated by the health maintenance organization.

(5) For purposes of this section:

(a) "Affiliated pharmacy" means a pharmacy that directly or indirectly through one or more intermediaries is owned by, controlled by, or is under common ownership or control of a pharmacy benefit manager, or where the pharmacy benefit manager has financial interest in the pharmacy.

(b) "Covered person" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

(c) "Health benefit plan" means any entity or program that provides reimbursement for pharmaceutical services.

(d) "Participating pharmacy" means a pharmacy that has entered into an agreement to provide prescription drugs to the pharmacy benefit manager's covered persons.

(e) "Pharmacy network" means the pharmacies located in and licensed by the state and contracted by the pharmacy benefit manager to sell prescription drugs to covered persons.

(f) "Specialty or limited distribution prescription drug" means a drug that's distribution is limited by a federal food and drug administration's element to assure safe use.

(6) This section applies to health benefit plans issued or renewed on or after January 1, 2023.

Sec. 2. RCW 48.200.020 and 2020 c 240 s 2 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

1 (1) "Affiliate" or "affiliated employer" means a person who
2 directly or indirectly through one or more intermediaries, controls
3 or is controlled by, or is under common control with, another
4 specified person.
5 (2) "Certification" has the same meaning as in RCW 48.43.005.
6 (3) "Employee benefits programs" means programs under both the
7 public employees' benefits board established in RCW 41.05.055 and the
8 school employees' benefits board established in RCW 41.05.740.
9 (4)(a) "Health care benefit manager" means a person or entity
10 providing services to, or acting on behalf of, a health carrier or
11 employee benefits programs, that directly or indirectly impacts the
12 determination or utilization of benefits for, or patient access to,
13 health care services, drugs, and supplies including, but not limited
14 to:
15 (i) Prior authorization or preauthorization of benefits or care;
16 (ii) Certification of benefits or care;
17 (iii) Medical necessity determinations;
18 (iv) Utilization review;
19 (v) Benefit determinations;
20 (vi) Claims processing and repricing for services and procedures;
21 (vii) Outcome management;
22 (viii) Provider credentialing and recredentialing;
23 (ix) Payment or authorization of payment to providers and
24 facilities for services or procedures;
25 (x) Dispute resolution, grievances, or appeals relating to
26 determinations or utilization of benefits;
27 (xi) Provider network management; or
28 (xii) Disease management.
29 (b) "Health care benefit manager" includes, but is not limited
30 to, health care benefit managers that specialize in specific types of
31 health care benefit management such as pharmacy benefit managers,
32 radiology benefit managers, laboratory benefit managers, and mental
33 health benefit managers.
34 (c) "Health care benefit manager" does not include:
35 (i) Health care service contractors as defined in RCW 48.44.010;
36 (ii) Health maintenance organizations as defined in RCW
37 48.46.020;
38 (iii) Issuers as defined in RCW 48.01.053;
39 (iv) The public employees' benefits board established in RCW
40 41.05.055;

1 (v) The school employees' benefits board established in RCW
2 41.05.740;
3 (vi) Discount plans as defined in RCW 48.155.010;
4 (vii) Direct patient-provider primary care practices as defined
5 in RCW 48.150.010;
6 (viii) An employer administering its employee benefit plan or the
7 employee benefit plan of an affiliated employer under common
8 management and control;
9 (ix) A union administering a benefit plan on behalf of its
10 members;
11 (x) An insurance producer selling insurance or engaged in related
12 activities within the scope of the producer's license;
13 (xi) A creditor acting on behalf of its debtors with respect to
14 insurance, covering a debt between the creditor and its debtors;
15 (xii) A behavioral health administrative services organization or
16 other county-managed entity that has been approved by the state
17 health care authority to perform delegated functions on behalf of a
18 carrier;
19 (xiii) A hospital licensed under chapter 70.41 RCW or ambulatory
20 surgical facility licensed under chapter 70.230 RCW;
21 (xiv) The Robert Bree collaborative under chapter 70.250 RCW;
22 (xv) The health technology clinical committee established under
23 RCW 70.14.090; or
24 (xvi) The prescription drug purchasing consortium established
25 under RCW 70.14.060.
26 (5) "Health care provider" or "provider" has the same meaning as
27 in RCW 48.43.005.
28 (6) "Health care service" has the same meaning as in RCW
29 48.43.005.
30 (7) "Health carrier" or "carrier" has the same meaning as in RCW
31 48.43.005.
32 (8) "Laboratory benefit manager" means a person or entity
33 providing service to, or acting on behalf of, a health carrier,
34 employee benefits programs, or another entity under contract with a
35 carrier, that directly or indirectly impacts the determination or
36 utilization of benefits for, or patient access to, health care
37 services, drugs, and supplies relating to the use of clinical
38 laboratory services and includes any requirement for a health care
39 provider to submit a notification of an order for such services.

1 (9) "Mental health benefit manager" means a person or entity
2 providing service to, or acting on behalf of, a health carrier,
3 employee benefits programs, or another entity under contract with a
4 carrier, that directly or indirectly impacts the determination of
5 utilization of benefits for, or patient access to, health care
6 services, drugs, and supplies relating to the use of mental health
7 services and includes any requirement for a health care provider to
8 submit a notification of an order for such services.
9 (10) "Network" means the group of participating providers,
10 pharmacies, and suppliers providing health care services, drugs, or
11 supplies to beneficiaries of a particular carrier or plan.
12 (11) "Person" includes, as applicable, natural persons, licensed
13 health care providers, carriers, corporations, companies, trusts,
14 unincorporated associations, and partnerships.
15 (12)(a) "Pharmacy benefit manager" means a person that contracts
16 with pharmacies on behalf of an insurer, a third-party payor, or the
17 prescription drug purchasing consortium established under RCW
18 70.14.060 to:
19 (i) Process claims for prescription drugs or medical supplies or
20 provide retail network management for pharmacies or pharmacists;
21 (ii) Pay pharmacies or pharmacists for prescription drugs or
22 medical supplies;
23 (iii) Negotiate rebates with manufacturers for drugs paid for or
24 procured as described in this subsection;
25 (iv) Manage pharmacy networks; or
26 (v) Make credentialing determinations.
27 (b) "Pharmacy benefit manager" does not include a health care
28 service contractor as defined in RCW 48.44.010.
29 (13)(a) "Radiology benefit manager" means any person or entity
30 providing service to, or acting on behalf of, a health carrier,
31 employee benefits programs, or another entity under contract with a
32 carrier, that directly or indirectly impacts the determination or
33 utilization of benefits for, or patient access to, the services of a
34 licensed radiologist or to advanced diagnostic imaging services
35 including, but not limited to:
36 (i) Processing claims for services and procedures performed by a
37 licensed radiologist or advanced diagnostic imaging service provider;
38 or

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

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

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

(15) "Critical access pharmacy" means a pharmacy in Washington that is further than a 15-mile radius from any other pharmacy, is the only pharmacy on an island, or provides critical services to vulnerable populations. If one critical access pharmacy's 15-mile radius intersects with that of another critical access pharmacy, both shall be considered a critical access pharmacy if either critical access pharmacy's closure could result in impaired access for rural areas or for vulnerable populations. The health care authority's chief pharmacy officer may also further identify pharmacies as critical access based on their unique ability to care for a population.

NEW SECTION. **Sec. 3.** A new section is added to chapter 48.200 RCW to read as follows:

If a pharmacy benefit manager or a managed health care system as defined in RCW 74.09.522 offers a distinct reimbursement to rural pharmacies, it shall provide a similar reimbursement to critical access pharmacies if the critical access pharmacy agrees to the terms and conditions set for affiliated pharmacies and the network as established by the health plan.

Sec. 4. RCW 48.200.280 and 2020 c 240 s 15 are each amended to read as follows:

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

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

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

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

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

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

(2) A pharmacy benefit manager:

(a) May not place a drug on a list unless there are at least two therapeutically equivalent multiple source drugs, or at least one generic drug available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers;

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

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

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

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

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

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

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

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

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

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

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

(i) The original claim was submitted fraudulently; or

(ii) The denial or reduction is the result of a pharmacy audit conducted in accordance with RCW 48.200.220.

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

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

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

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

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

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

(b) If the request for an adjustment has come from a critical access pharmacy, ((~~as defined by the state health care authority by rule for purposes related to the prescription drug purchasing consortium established under RCW 70.14.060,~~)) the adjustment approved under (a) of this subsection shall apply only to critical access pharmacies.

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

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

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

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

1 (d) A pharmacy benefit manager may not retaliate against a
2 pharmacy for pursuing an appeal under this subsection (6).
3 (e) This subsection (6) applies only to a pharmacy with fewer
4 than fifteen retail outlets, within the state of Washington, under
5 its corporate umbrella.
6 (7) This section does not apply to the state medical assistance
7 program."

8 Correct the title.

EFFECT: Removes the prohibitions on pharmacy benefit managers (PBMs) imposing different days allowance to fill at participating pharmacies and reimbursing a nonparticipating pharmacy more than a participating pharmacy.

Removes the requirement that a PBM must provide fair and reasonable reimbursement to participating pharmacies.

Requires PBMs, regardless of the participating pharmacy including mail order, to apply the same copays, fees, days allowance, and other conditions upon enrollees.

Removes the requirement that pharmacy services administrative organizations must include a provision in contracts with participating pharmacies that a pharmacy may decline to fill a prescription if the reimbursement is not at least equal to the pharmacy's acquisition cost.

Applies the requirement that PBMs that offer distinct reimbursement to rural pharmacies must provide similar reimbursement to critical access pharmacies that agree to certain terms to managed health care systems.

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