
ENGROSSED SUBSTITUTE HOUSE BILL 1813

State of Washington

67th Legislature

2022 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Schmick, Macri, Graham, and Chambers)

READ FIRST TIME 02/03/22.

1 AN ACT Relating to freedom of pharmacy choice; amending RCW
2 48.200.020 and 48.200.280; and adding new sections to chapter 48.200
3 RCW.

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

5 NEW SECTION. **Sec. 1.** A new section is added to chapter 48.200
6 RCW to read as follows:

7 (1) A pharmacy benefit manager that administers a prescription
8 drug benefit may not:

9 (a) Require a covered person to use a mail order pharmacy;

10 (b) Require a covered person to obtain prescriptions from a mail
11 order pharmacy unless the prescription drug is a specialty or limited
12 distribution prescription drug; or

13 (c) Reimburse a covered person's chosen participating pharmacy an
14 amount less than the amount the pharmacy benefit manager reimburses
15 participating affiliated pharmacies.

16 (2) A pharmacy benefit manager shall:

17 (a) Include a provision in contracts with participating
18 pharmacies and pharmacy services administrative organizations that
19 authorizes the pharmacy to decline to fill a prescription if the
20 pharmacy benefit manager refuses to reimburse the pharmacy at a rate

1 that is at least equal to the pharmacy's acquisition cost of the
2 drug;

3 (b) Maintain an adequate and accessible pharmacy network for the
4 provision of prescription drugs for a health benefit plan. The
5 pharmacy network must provide for convenient access for covered
6 persons to pharmacies and critical access pharmacies;

7 (c) Regardless of the participating pharmacy, including mail
8 order pharmacies, where the covered person obtains the prescription
9 drug, apply the same copays, fees, days allowance, and other
10 conditions upon the enrollee; and

11 (d) Permit the covered person to receive delivery or mail order
12 of a medication through any participating pharmacy.

13 (3) If a covered person is using a mail order pharmacy, the
14 pharmacy benefit manager must:

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

18 (i) If there are delays in mail order;

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

20 or

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

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

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

28 (5) For purposes of this section:

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

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

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

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

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

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

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

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

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

16 (1) "Affiliate" or "affiliated employer" means a person who
17 directly or indirectly through one or more intermediaries, controls
18 or is controlled by, or is under common control with, another
19 specified person.

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

21 (3) "Employee benefits programs" means programs under both the
22 public employees' benefits board established in RCW 41.05.055 and the
23 school employees' benefits board established in RCW 41.05.740.

24 (4)(a) "Health care benefit manager" means a person or entity
25 providing services to, or acting on behalf of, a health carrier or
26 employee benefits programs, that directly or indirectly impacts the
27 determination or utilization of benefits for, or patient access to,
28 health care services, drugs, and supplies including, but not limited
29 to:

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

31 (ii) Certification of benefits or care;

32 (iii) Medical necessity determinations;

33 (iv) Utilization review;

34 (v) Benefit determinations;

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

36 (vii) Outcome management;

37 (viii) Provider credentialing and recredentialing;

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

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

3 (xi) Provider network management; or
4 (xii) Disease management.

5 (b) "Health care benefit manager" includes, but is not limited
6 to, health care benefit managers that specialize in specific types of
7 health care benefit management such as pharmacy benefit managers,
8 radiology benefit managers, laboratory benefit managers, and mental
9 health benefit managers.

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

11 (i) Health care service contractors as defined in RCW 48.44.010;
12 (ii) Health maintenance organizations as defined in RCW
13 48.46.020;
14 (iii) Issuers as defined in RCW 48.01.053;
15 (iv) The public employees' benefits board established in RCW
16 41.05.055;
17 (v) The school employees' benefits board established in RCW
18 41.05.740;
19 (vi) Discount plans as defined in RCW 48.155.010;
20 (vii) Direct patient-provider primary care practices as defined
21 in RCW 48.150.010;
22 (viii) An employer administering its employee benefit plan or the
23 employee benefit plan of an affiliated employer under common
24 management and control;
25 (ix) A union administering a benefit plan on behalf of its
26 members;

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

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

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

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

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

38 (xv) The health technology clinical committee established under
39 RCW 70.14.090; or

1 (xvi) The prescription drug purchasing consortium established
2 under RCW 70.14.060.

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

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

7 (7) "Health carrier" or "carrier" has the same meaning as in RCW
8 48.43.005.

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

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

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

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

31 (12)(a) "Pharmacy benefit manager" means a person that contracts
32 with pharmacies on behalf of an insurer, a third-party payor, or the
33 prescription drug purchasing consortium established under RCW
34 70.14.060 to:

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

37 (ii) Pay pharmacies or pharmacists for prescription drugs or
38 medical supplies;

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

1 (iv) Manage pharmacy networks; or

2 (v) Make credentialing determinations.

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

5 (13)(a) "Radiology benefit manager" means any person or entity
6 providing service to, or acting on behalf of, a health carrier,
7 employee benefits programs, or another entity under contract with a
8 carrier, that directly or indirectly impacts the determination or
9 utilization of benefits for, or patient access to, the services of a
10 licensed radiologist or to advanced diagnostic imaging services
11 including, but not limited to:

12 (i) Processing claims for services and procedures performed by a
13 licensed radiologist or advanced diagnostic imaging service provider;
14 or

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

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

22 (14) "Utilization review" has the same meaning as in RCW
23 48.43.005.

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

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

37 If a pharmacy benefit manager or a managed health care system as
38 defined in RCW 74.09.522 offers a distinct reimbursement to rural
39 pharmacies, it shall provide a similar reimbursement to critical

1 access pharmacies if the critical access pharmacy agrees to the terms
2 and conditions set for affiliated pharmacies and the network as
3 established by the health plan.

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

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

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

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

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

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

27 (e) "Therapeutically equivalent" has the same meaning as in RCW
28 69.41.110.

29 (2) A pharmacy benefit manager:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37 (3) A pharmacy benefit manager must establish a process by which
38 a network pharmacy may appeal its reimbursement for a drug subject to
39 predetermined reimbursement costs for multisource generic drugs. A
40 network pharmacy may appeal a predetermined reimbursement cost for a

1 multisource generic drug if the reimbursement for the drug is less
2 than the net amount that the network pharmacy paid to the supplier of
3 the drug. An appeal requested under this section must be completed
4 within thirty calendar days of the pharmacy submitting the appeal. If
5 after thirty days the network pharmacy has not received the decision
6 on the appeal from the pharmacy benefit manager, then the appeal is
7 considered denied.

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

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

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

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

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

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

37 (6) Beginning July 1, 2017, if a network pharmacy appeal to the
38 pharmacy benefit manager is denied, or if the network pharmacy is
39 unsatisfied with the outcome of the appeal, the pharmacy or

1 pharmacist may dispute the decision and request review by the
2 commissioner within thirty calendar days of receiving the decision.

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

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

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

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

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

20 (7) This section does not apply to the state medical assistance
21 program.

--- END ---