R 2024-02 Health care benefit managers

First Prepublication Draft | July 12, 2024

Comments due to OIC at rulescoordinator@oic.wa.gov by July 26, 2024

Chapter 284-180 WAC

HEALTH CARE BENEFIT MANAGERS

SUBCHAPTER A

GENERAL PROVISIONS

WAC 284-180-120 Applicability and scope. (1) This chapter applies to health care benefit managers as defined in RCW 48.200.020, ~~to~~ health carriers, ~~to Medicaid managed care organizations~~, and ~~to those S~~self-funded group health plans~~,~~ and union plans that have elected under section 9 of Chap. 242, Laws of 2024 to participate in sections 5, 7 and 8 of Chap. 242, Laws of 2024. ~~Additionally, t~~This chapter also applies to pharmacy benefit managers who contract with pharmacies on behalf of health carriers, Medicaid managed care organizations, and self-

funded group health plans that have elected under section 9 of Chap. 242, Laws of 2024 to participate in sections 5, 7, and 8 of Chap. 2412, Laws of 2024.

~~(2) This chapter does not apply to the actions of health care benefit managers providing services to, or acting on behalf of:~~

~~(a) Self-~~funded ~~insured~~ group ~~health plans~~, ~~except to the extent that a self-funded group health plan has elected under section 9 of Chap. 242, Laws of 2024 to participate in sections 5,7 and 8 of Chap. 242, Laws of 2024~~;

~~(b) Medicare plans;~~

~~(c) Medicaid; and~~

~~(d) Union plans~~

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-120, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-120, filed 12/20/16, effective 1/1/17.]

WAC 284-180-130 Definitions. Except as defined in other subchapters and unless the context requires otherwise, the following definitions apply throughout this chapter:

(1) "Affiliate" or "affiliated employer" has the same meaning as the definition of affiliate or affiliated employer in RCW 48.200.020.

(2) "Annual gross income" means the sum of all amounts paid during a calendar year by any entities with which a health care benefit manager has contracted for the provision of health care benefit management services in Washington state.

(3) "Certification" has the same meaning as the definition of certification in RCW 48.43.005.

(4) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through ownership of voting securities, membership rights, by contract, or otherwise.

(5~~3~~) "Corporate umbrella" means an arrangement consisting of, but not limited to, subsidiaries and affiliates operating under common ownership or control.

(6~~4~~) “Covered person” has the same meaning as in RCW 48.43.005.

(7) As used in RCW 48.200.020, “credentialing” means the collection, verification, and assessment of whether a health care provider meets relevant licensing, education, and training requirements.

(8~~4~~) "Employee benefits programs" has the same meaning as the definition of employee benefits program in RCW 48.200.020.

(9~~5~~) "Generally available for purchase" means available for purchase by multiple pharmacies within the state of Washington from national or regional wholesalers.

(10~~6~~) "Health care benefit manager" has the same meaning as the definition of health care benefit manager in RCW 48.200.020.

(11~~7~~) "Health care provider" or "provider" has the same meaning as the definition of health care provider in RCW 48.43.005.

(12~~8~~) "Health care services" has the same meaning as the definition of health care services in RCW 48.43.005.

(13~~9~~) "Health carrier" or “carrier” has the same meaning as the definition of health carrier in RCW 48.43.005.

(14 ~~10~~) "Laboratory benefit manager" has the same meaning as the definition of laboratory benefit manager in RCW 48.43.020.

(15) "List" has the same meaning as the definition of list in RCW 48.200.280.

(16) "Mail order pharmacy" has the same meaning as the definition of mail order pharmacy in RCW 48.200.020.

(17 ~~11~~) "Mental health benefit manager" has the same meaning as the definition of mental health benefit manager in RCW 48.200.020.

(18) "Multiple source drug" has the same meaning as the definition of multiple source drug in RCW 48.200.280.

(19 ~~12~~) "Net amount" means the invoice price that the pharmacy paid to the supplier for a prescription drug that it dispensed, plus any taxes, fees or other costs, minus the amount of all discounts and other cost reductions attributable to the drug.

(20 ~~13~~) "Network" has the same meaning as the definition of network in RCW 48.200.020.

(21) "Network pharmacy" has the same meaning as the definition of network pharmacy in RCW 48.200.280.

(22~~14~~) "Oversight activities" includes all work done by the commissioner to ensure that the requirements of chapter 48.200 RCW are properly followed and in fulfilling its duties as required under chapter 48.200 RCW.

(23~~15~~) "Person" has the same meaning as the definition of person in RCW 48.200.020.

(24 ~~16~~) "Pharmacy benefit manager" has the same meaning as the definition of pharmacy benefit manager in RCW 48.200.020.

(25) "Pharmacy network" has the same meaning as the definition of pharmacy network in RCW 48.200.020.

(26~~17~~) "Predetermined reimbursement cost" means maximum allowable cost, maximum allowable cost list, or any other benchmark price utilized by the pharmacy benefit manager, including the basis of the methodology and sources utilized to determine multisource generic drug reimbursement amounts. However, dispensing fees are not included in the calculation of predetermined reimbursement costs for multisource generic drugs.

(27~~6~~ ~~18~~) "Radiology benefit manager" has the same meaning as the definition of radiology benefit manager in RCW 48.200.020.

(28~~7~~ ~~19~~) "Readily available for purchase" means manufactured supply is held in stock and available for order by more than one pharmacy in Washington state when such pharmacies are not under the same corporate umbrella.

(29~~8~~ ~~20~~) "Retaliate" means action, or the implied or stated threat of action, to decrease reimbursement or to terminate, suspend, cancel or limit a pharmacy's participation in a pharmacy benefit manager's provider network solely or in part because the pharmacy has filed or intends to file an appeal under RCW 48.200.280.

(30~~29~~ ~~21~~) "Unsatisfied" means that the network pharmacy did not receive the reimbursement that it requested at the first tier appeal.

(31~~0~~ ~~22~~) "Utilization review" has the same meaning as the definition of utilization review in RCW 48.43.005.

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-130, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100,

19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-130, filed 12/20/16, effective 1/1/17.]

SUBCHAPTER B

REGISTRATION AND RENEWAL

WAC 284-180-210 Registration and renewal fees. (1) The commissioner must establish fees for registration and renewal in an amount that ensures the program for the registration, renewal, and oversight activities of the health care benefit managers is self-supporting. Each health care benefit manager must contribute a sufficient amount to the commissioner's regulatory account to pay for the reasonable costs, including overhead, of regulating health care benefit managers.

(2) The initial registration fee is $750 ~~200~~.

(3) For the renewal fee, the commissioner will charge a proportional share of the annual cost of the insurance commissioner's renewal and oversight activities of health care benefit managers. Each health care benefit managers' proportional share of the program annual operating costs will be based on their Washington state annual gross income of their

health care benefit manager business for the previous calendar year. The renewal fee is $1,000 ~~500~~, at a minimum, and may increase based on a proportional share of each health care benefit manager's Washington state annual gross income as reported to the insurance commissioner.

(4) If an unexpended balance of health care benefit manager registration and renewal funds remain in the insurance commissioner's regulatory account at the close of a fiscal year, the commissioner will carry the unexpended funds forward and use them to reduce future renewal fees.

[Statutory Authority: RCW 48.02.060, 48.200.280(6), 34.05.485 (1)€, and 48.02.100. WSR 23-23-141 (Matter R 2023-06), § 284-180-210, filed 11/20/23, effective 12/21/23. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-210, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-210, filed 12/20/16, effective 1/1/17.]

WAC 284-180-220 Health care benefit manager registration.

(1) Beginning January 1, 2022, and thereafter, to conduct business in this state, health care benefit managers must have

an approved registration~~er~~ as provided in RCW 48.200.030 and section 6 of Chap. 242, Laws of 2024. The registration application is not complete until the commissioner receives the complete registration form, any supporting documentation if required by the commissioner, and paid the $750 registration fee.

~~, and have an approved registration with the commissioner~~

(2) Health care benefit managers must apply for registration using the commissioner's electronic system, which is available at www.insurance.wa.gov.

(3) The registration period is valid from the date of approval of registration through June 30th of the same fiscal year.

~~(4) The registration application is not complete until the commissioner receives the complete registration form, any supporting documentation if required by the commissioner, and paid the $200 registration fee.~~

~~(5) A health care benefit manager may conduct business in this state after receiving notice of approval of the registration application from the commissioner.~~

[Statutory Authority: RCW 48.02.060, 48.200.280(6), 34.05.485 (1)€, and 48.02.100. WSR 23-23-141 (Matter R 2023-06), § 284-180-220, filed 11/20/23, effective 12/21/23. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-220, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-220, filed 12/20/16, effective 1/1/17.]

WAC 284-180-230 Health care benefit manager renewal. (1) Health care benefit managers annually renew their registrations as provided in RCW 48.200.030 and pay their renewal fee using the commissioner's electronic system, which is available at www.insurance.wa.gov.

(2) Health care benefit managers renewing their registrations must, no later than March 1st of each year, submit an electronic renewal report and supporting documents for approval to include:

(a) Their Washington state annual gross income for health care benefit manager business for the previous calendar year, broken down by Washington state annual gross income received

from each entity with which the health care benefit manager has contracted during the previous calendar year; and

(b) Any additional information, including supporting documents, as required by the commissioner.

(3) Health care benefit managers ~~may amend their annual gross income report for the previous year after the date of submission, but~~ may not amend their Washington state annual gross income ~~the~~ report for the previous year later than April 1 ~~May 31st~~, of the submission year.

(4) On or before June 1st of each year, the commissioner will calculate and set the renewal fees for the next July 1st through June 30th fiscal year. Invoices for the renewal fees and electronic payments will be available through the insurance commissioner's electronic filing and payment center. Renewal fee payments are due by July 15th of each year.

(5) The renewal application is not complete until the commissioner receives the complete renewal report, supporting documentation if required by the commissioner, and the payment of the invoiced renewal fee.

(6) Upon successful completion, the health care benefit manager will receive notice of approval of the renewal application from the commissioner.

(7) Failure to timely submit a completed renewal report and fee may result in a delayed renewal or nonrenewal in addition to potential violations if a health care benefit manager provides services without being registered.

(8) Each renewed registration is valid for one fiscal year from July 1st through June 30th fiscal year.

[Statutory Authority: RCW 48.02.060, 48.200.280(6), 34.05.485 (1)€, and 48.02.100. WSR 23-23-141 (Matter R 2023-06), § 284-180-230, filed 11/20/23, effective 12/21/23. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-230, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-230, filed 12/20/16, effective 1/1/17.]

WAC 284-180-240 Providing and updating registration information. (1) When registering, a health care benefit manager must submit with its application ~~apply with~~ an affidavit affirming the application's ~~its~~ accuracy. An application for

registering as a health care benefit manager must include ~~provide for~~:

(a) The legal name as well as any additional names that it uses to conduct business;

(b) The names of persons and entities with any ownership or controlling interests, including stockholders, officers and directors, or limited liability company members, managers and officers in the health care benefit manager, and the identity of any entity for which the health care benefit manager has a controlling interest;

(c) A list of tax identification numbers and business licenses and registrations that are active;

(d) Identifying any areas of specialty, such as a pharmacy benefit management, radiology benefit management, laboratory benefit management, mental health care benefit management, or any other areas of specialty identified in the application;

(e) A copy of the health care benefit manager's certificate of registration with the Washington state secretary of state;

(f ~~e~~) Contact information for communications regarding registration, renewal and oversight activities, to include name

of the contact person, address, phone number, and valid email address;

(g ~~f~~) Name and contact information for the person the health care benefit manager has designated as responsible for compliance with state and federal laws to include name of the contact person, address, phone number, and valid email address;

(h~~g~~) Identify if the health care benefit manager has committed any violations in this or any state or been the subject of an order from a any federal or state agency or court; and

(i ~~h~~) Any additional information requested by the commissioner.

(2) Registered health care benefit managers must provide any material change in the information filed with the commissioner.

(a) This information includes, but is not limited to:

(i) Any additional names that the health care benefit manager uses to conduct business; and

(ii) The contact's name and email address for official communications between the commissioner and the health care

benefit manager as required in subsection (1)(f) of this section.

(b) Any change in the information provided to obtain, renew, nonrenew, or surrender a registration as a health care benefit manager is a material change and must be reported to the commissioner within 30 days of the change.

(c)~~€~~ Any amendments to its annual renewal reports including the reported annual gross income must be reported to the commissioner no later than May 31st. Amended annual renewal reports may be accepted after review by the commissioner. [Statutory Authority: RCW 48.02.060, 48.200.280(6), 34.05.485 (1)€, and 48.02.100. WSR 23-23-141 (Matter R 2023-06), § 284-180-240, filed 11/20/23, effective 12/21/23. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-240, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 48.02.220 and chapter 19.340 RCW. WSR 18-13-023, § 284-180-240, filed 6/8/18, effective 7/9/18. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-240, filed 12/20/16, effective 1/1/17.]

SUBCHAPTER C

RECORDS AND NOTICES

WAC 284-180-325 Required notices. (1) Carriers must post on their website information that identifies each health care benefit manager contracted with the carrier, either directly or indirectly through subcontracting with a health care benefit manager or other entity, and identify the services provided by each of the health care benefit managers ~~s~~ the carrier has contracts with, either directly or indirectly. The information must be easy to find and prominently displayed on the carriers' website with a link from the web page utilized for enrollees. The carrier is required to update the information on their website within thirty business days of any change, such as addition or removal of a health care benefit manager or a change in the services provided by a health care benefit manager.

(2) Carriers must notify enrollees in writing and at least annually, including at plan enrollment and renewal, of each health care benefit manager contracted with the carrier to provide any health care benefit management services, either

directly or indirectly through subcontracting with a health care benefit manager or other entity. For example, written notices include disclosure in the policy or member handbook. This notice must identify the website address where enrollees can view an updated listing of all health care benefit managers utilized by the carrier.

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-325, filed 12/29/20, effective 1/1/22.]

SUBCHAPTER D

CONTRACT FILINGS

WAC 284-180-405 Definitions in this subchapter. The definitions in this section apply throughout this subchapter.

(1) "Complete filing" means a package of information containing forms, supporting information, documents and exhibits submitted to the commissioner electronically using the system for electronic rate and form filing (SERFF).

(2) "Date filed" means the date a complete filing has been received and accepted by the commissioner.

(3) "Filer" means:

(a) A person, organization or other entity that files forms or rates with the commissioner for a carrier or health care benefit manager; or

(b) A person employed by a carrier or heath care benefit manager to file under this chapter.

(4) ~~"Form" means a~~ "~~h~~Health care benefit management contract form" or "contract" or "form" ~~and~~ means any written agreement describing the rights and responsibilities of the parties, such as carriers, health care benefit managers, providers, pharmacy, pharmacy services administration organization, and employee benefit program conforming to chapter 48.200 RCW and this chapter including:

(a) All forms that are part of the contract; and

(b) All amendments to the contract.

(5) "NAIC" means the National Association of Insurance Commissioners.

(6) "Objection letter" means correspondence created in SERFF and sent by the commissioner to the filer that:

(a) Requests clarification, documentation, or other information; or

(b) Explains errors or omissions in the filing.

(7) "SERFF" means the system for electronic rate and form filing. SERFF is a proprietary NAIC computer-based application that allows insurers and other entities to create and submit rate, rule, and form filings electronically to the commissioner.

(8) "Type of insurance" or "TOI" means a specific type of health care coverage listed in the *Uniform Life, Accident and Health, Annuity and Credit Coding Matrix* published by the NAIC and available at www.naic.org.

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-405, filed 12/29/20, effective 1/1/22.]

WAC 284-180-411 Purpose of this subchapter. The purpose of this subchapter is to:

(1) Adopt processes and procedures for filers to use when submitting electronic forms and rates to the commissioner by way of SERFF.

(2) Designate SERFF as the method by which filers, including ~~health care service contractors, health maintenance organizations, insurers as defined in RCW 48.01.050~~ carriers~~,~~

and health care benefit managers must submit all health care benefit management contract forms to the commissioner. [Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-411, filed 12/29/20, effective 1/1/22.]

WAC 284-180-455 Carrier filings related to health care benefit managers. (1) A carrier must file all contracts and contract amendments ~~with~~ between a health care benefit manager and carrier, within thirty days following the effective date of the contract or contract amendment. Contracts that must be filed by a carrier under RCW 48.43.731 shall include all contracts to directly or indirectly provide health care benefit management services on behalf of a carrier, such as but not limited to, health care benefit management services contracts that result from a carrier contracting with a health care benefit manager who then contracts or subcontracts with another health care benefit manager.

(2) If a carrier negotiates, amends, or modifies a contract or a compensation agreement that deviates from a previously filed contract, then the carrier must file that negotiated, amended, or modified contract or agreement with the commissioner

within thirty days following the effective date. The commissioner must receive the filings electronically in accordance with this subchapter.

(~~2~~ 3) Carriers must maintain health care benefit manager contracts at its principal place of business in the state, or the carrier must have access to all contracts and provide copies to facilitate regulatory review upon twenty days prior written notice from the commissioner.

(4 ~~3~~) Nothing in this section relieves the carrier of the responsibility detailed in WAC 284-170-280 (3)(b) to ensure that all contracts are current and signed if the carrier utilizes a health care benefit manager's providers and those providers are listed in the network filed for approval with the commissioner.

(~~4~~ 5) If a carrier enters into a reimbursement agreement that is tied to health outcomes, utilization of specific services, patient volume within a specific period of time, or other performance standards, the carrier must file the reimbursement agreement with the commissioner within thirty days following the effective date of the reimbursement agreement, and identify the number of enrollees in the service area in which

the reimbursement agreement applies. Such reimbursement agreements must not cause or be determined by the commissioner to result in discrimination against or rationing of medically necessary services for enrollees with a specific covered condition or disease. If the commissioner fails to notify the carrier that the agreement is disapproved within thirty days of receipt, the agreement is deemed approved. The commissioner may subsequently withdraw such approval for cause.

(6 ~~5~~) Health care benefit manager contracts and compensation agreements must clearly set forth the carrier provider networks and applicable compensation agreements associated with those networks so that the provider or facility can understand their participation as an in-network provider and the reimbursement to be paid. The format of such contracts and agreements may include a list or other format acceptable to the commissioner so that a reasonable person will understand and be able to identify their participation and the reimbursement to be paid as a contracted provider in each provider network. [Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-455, filed 12/29/20, effective 1/1/22.]

WAC 284-180-460 Health care benefit manager filings. (1) A health care benefit manager must file all contracts and contract amendments between the health care benefit manager and a health carrier, provider, pharmacy, pharmacy services administration organization, or other health care benefit manager entered into directly or indirectly in support of a contract with a carrier or employee benefits program within 30 days following the effective date of the contract or contract amendment. Contracts that must be filed by a health care benefit manager shall include all contracts to directly or indirectly provide health care benefit management services on behalf of a carrier, such as but not limited to health care benefit management services contracts that result from a carrier contracting with a health care benefit manager who then contracts or subcontracts with another health care benefit manager.

(2) If a health care benefit manager negotiates, amends, or modifies a contract or a compensation agreement that deviates from a filed agreement, then the health care benefit manager

must file that negotiated, amended, or modified contract or agreement with the commissioner within 30 days following the effective date. The commissioner must receive the filings electronically in accordance with this chapter.

(3 ~~2~~) Contracts or contract amendments that were executed prior to July 23, 2023, and remain in force, must be filed with the commissioner no later than 60 days following July 23, 2023.

(4 ~~3~~) Health care benefit managers must maintain health care benefit management contracts at its principal place of business in the state, or the health care benefit manager must have access to all contracts and provide copies to facilitate regulatory review upon 20 days prior written notice from the commissioner.

(5 ~~4~~) Health care benefit manager contracts and compensation agreements must clearly set forth provider network names and applicable compensation agreements associated with those networks so that the provider or facility can understand their participation as an in-network provider and the reimbursement to be paid. The format of such contracts and agreements may include a list or other format acceptable to the

commissioner so that a reasonable person will understand and be able to identify their participation and the reimbursement to be paid as a contracted provider in each provider network.

[Statutory Authority: RCW 48.02.060, 48.43.735, 48.44.050, 48.46.200, 48.200.040, and 48.200.900. WSR 23-24-034 (Matter R 2023-07), § 284-180-460, filed 11/30/23, effective 1/1/24. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-460, filed 12/29/20, effective 1/1/22.]

New Section. WAC 284-180-465. Self-funded group health plan opt-in.

(1) A self-funded group health plan that elects under section 9 of Chap. 242, Laws of 2024 to participate in sections 5,7 and 8 of Chap. 242, Laws of 2024 shall provide notice to the commissioner of their election decision on a form prescribed by the commissioner. Election decisions are effective beginning January 1, 2026. The completed form must include an attestation that the self-funded group health plan has elected to participate in and be bound by sections 5, 7 and 8 of Chap. 242, Laws of 2024 and rules adopted to implement those sections of law. If the form is completed by the self-funded group health plan, the plan must inform any entity that administers the plan of their election to participate. The form will be posted on the

commissioner's public website for use by self-funded group health plans.

(2) A self-funded group health plan election to participate is for a full year. The plan may elect to initiate its participation on January 1st of any year or in any year on the first day of the self-funded group health plan's plan year.

(3) A self-funded group health plan's election occurs on an annual basis. On its election form, the plan must indicate whether it chooses to affirmatively renew its election on an annual basis or whether it should be presumed to have renewed on an annual basis until the commissioner receives advance notice from the plan that it is terminating its election as of either December 31st of a calendar year or the last day of its plan year. Notices under this subsection must be submitted to the commissioner at least 15 days in advance of the effective date of the election to initiate participation and the effective date of the termination of participation.

(4) A self-funded plan operated by an out-of-state employer that has at least one employee who resides in Washington state may elect to participate in pharmacy benefit manager regulation as provided in section 9 of Chap. 242, Laws of 2024 on behalf of their Washington state resident employees and dependents. If a self-funded group health plan established by Washington state employer has elected to participate under section 9 of Chap.

242, Laws of 2024 in sections 5, 7 and 8 of Chap. 242, Laws of 2024 and has employees that reside in other states, those employees are protected by sections 5, 7 and 8 of Chap. 242, Laws of 2024 when filling a prescription ordered by a provider in Washington state or at a pharmacy located in Washington state.

SUBCHAPTER E

APPEALS

NOTE: The amendments to WAC 284-180-505, -515 and -520 in this SUBCHAPTER E that implement Sec. 5(4) of Chap. 242, Laws of 2024 and expand the types of prescription drug claims subject to appeal under Sec. 5(3) of Chap. 242, Laws of 2024, take effect January 1, 2026, per Sec. 12 of Chap. 242, Laws of 2024. The CR-102 will be drafted to address the differing effective dates of the affected rule provisions.

WAC 284-180-500 Applicability and scope. This subchapter applies to ~~health care benefit managers providing pharmacy~~

~~benefit management services, referred to as~~ pharmacy benefit managers as defined in RCW 48.200.020. ~~in this subchapter.~~

(1) Specifically, this subchapter applies to the actions of pharmacy benefit managers regarding contracts with pharmacies on behalf of ~~an insurer, a third-party payor, or the prescription drug purchasing consortium established under RCW 70.14.060~~ a carrier, employee benefits program, or Medicaid managed care program in regard to:

(a) Fully insured health plans; and

(b) Medicaid managed care plans. However, the appeal requirements of RCW 19.340.100 do not apply to ~~29~~medicaid managed care plans.

(2) This subchapter does not apply to:

(a) ~~t~~The actions of pharmacy benefit managers contracting with ~~acting as~~ third-party administrators to administer prescription drug benefits for: ~~regarding contracts with pharmacies on behalf of an insurer, a third-party payor, or the prescription drug purchasing consortium established under RCW 70.14.060 in regard to:~~

~~(a)~~ ~~S~~self-funded group ~~insured~~ health plans or union plans, unless a self-funded group health plan or union plan has elected to participate in sections 5, 7 and 8 of Chap. 242, Laws of 2024 under WAC 284-180-465; and

(b) The actions of pharmacy benefit managers contracting to administer prescription drug benefits for Medicare plans.

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-500, filed 12/29/20, effective 1/1/22.]

WAC 284-180-505 Appeals by network pharmacies to health care benefit managers who provide pharmacy benefit management services. (1) A network pharmacy, or its representative, may appeal the ~~a~~ reimbursement amount for a drug to a health care benefit manager providing pharmacy benefit management services (first tier appeal) if the reimbursement amount for the drug is less than the net amount the network pharmacy paid to the supplier of the drug and the claim was paid during the term of the current or immediate past contract between the network pharmacy and the pharmacy benefits manager.

(2) Before a pharmacy files an appeal pursuant to this section, upon request by a pharmacy or pharmacist, a pharmacy benefit manager must provide a current and accurate list of bank identification numbers, processor control numbers, and pharmacy group identifiers for health plans and for self-funded group health plans that have elected to participate in sections 5, 7, and 8 of this act through WAC 284-180-465 with which the pharmacy benefit manager either has a current contract or had a contract that has been terminated within the past 12 months to provide pharmacy benefit management services. ~~"Network pharmacy" has the meaning set forth in RCW 19.340.100 (1)(d). "Pharmacy benefit manager" is a health care benefit manager that offers pharmacy benefit management services and has the meaning set forth in RCW 48.200.020.~~

(3) A pharmacy benefit manager must process the network pharmacy's appeal as follows:

(a ~~1~~) A pharmacy benefit manager must include language in the pharmacy provider contract and on the pharmacy benefit manager's website fully describing the right to appeal under RCW 48.200.280. If the health care benefit manager provides other

health care benefit management services in addition to pharmacy benefit management services, ~~then~~ this information must be under an easily located page that is specific to pharmacy services. The description must include, but is not limited to:

(~~a~~ i) Contact information, including:

(~~i~~ A) A telephone number by which the pharmacy may contact the pharmacy benefit manager during normal business hours and speak with an individual responsible for processing appeals;

(B ~~ii~~) A summary of the specific times when the pharmacy benefit manager will answer calls from network pharmacies at that telephone number;

(C ~~iii~~) A fax number that a network pharmacy can use to submit information regarding an appeal; and

(D ~~iv~~) An email address that a network pharmacy can use to submit information regarding an appeal. Submission by a pharmacy of an appeal or information regarding an appeal to the email address included in the contract under this subsection must be accepted by the pharmacy benefit manager as a valid submission.

(ii ~~b~~) A detailed description of the actions that a network pharmacy must take to file an appeal; and

(iii)~~c~~ A detailed summary of each step in the pharmacy benefit manager's appeals process.

(4 ~~2~~) The pharmacy benefit manager must reconsider the reimbursement amount. A pharmacy benefit manager's review process must provide the network pharmacy or its representatives with an ~~the~~ opportunity to submit information to the pharmacy benefit manager including, but not limited to, documents or written comments. Documents or information that may be submitted by a network pharmacy to show that the reimbursement amount paid by a pharmacy benefit manager is less than the net amount that the network pharmacy paid to the supplier of the drug include but are not limited to:

(a) An image of information from the network pharmacy's wholesale ordering system;

(b) Other documentation showing the amount paid by the network pharmacy.

(5) The pharmacy benefit manager must review and investigate the reimbursement and consider all information submitted by the network pharmacy or its representatives prior to issuing a decision.

(6 ~~3~~) The pharmacy benefit manager must complete the appeal within thirty calendar days from the time the network pharmacy submits the appeal. If the network pharmacy does not receive the pharmacy benefit manager's decision within that time frame, then the appeal is deemed denied.

(~~4~~ 7) The pharmacy benefit manager must uphold the appeal of a network pharmacy with fewer than fifteen retail outlets within the state of Washington, under its corporate umbrella, if the pharmacy demonstrates that they are unable to purchase therapeutically equivalent interchangeable product from a supplier doing business in the state of Washington at the pharmacy benefit manager's list price. "Therapeutically equivalent" is defined in RCW 69.41.110~~(7)~~.

(8 ~~5~~) (a) If the pharmacy benefit manager denies the network pharmacy's appeal, the pharmacy benefit manager must provide the network pharmacy with a reason for the denial, ~~and~~ the national drug code of a drug that has been purchased by other network pharmacies located in the state of Washington at a price less than or equal to the ~~predetermined~~ reimbursement cost

for the ~~multisource generic drug~~ drug and the name of the wholesaler or supplier from which the drug was available for purchase at that price on the date of the claim or claims that are subject of the appeal. ~~"Multisource generic drug" is defined in RCW 19.340.100 (1)€.~~

(b) If the pharmacy benefit manager bases its denial on the fact that one or more of the claims that are the subject of the appeal is not subject to RCW 48.200.280 and this chapter, it must provide documentation clearly indicating as such in its denial notice.

(9 ~~6~~) If the pharmacy benefit manager upholds the network pharmacy's appeal, the pharmacy benefit manager must make a reasonable adjustment no later than one day after the date of the determination. The reasonable adjustment must include, at a minimum, payment of the claim or claims at issue at the net amount paid by the pharmacy to the supplier of the drug. The reasonable adjustment must also apply prospectively for a period of 90 days from the date of the upheld appeal. —If the request for an adjustment is from a critical access pharmacy, as defined by the state health care authority by rule for purpose related

to the prescription drug purchasing consortium established under RCW 70.14.060, any such adjustment shall apply only to such pharmacies.

(10 ~~7~~) If otherwise qualified, the following may file an appeal with a pharmacy benefit manager:

(a) Persons who are natural persons representing themselves;

(b) Attorneys at law duly qualified and entitled to practice in the courts of the state of Washington;

(c) Attorneys at law entitled to practice before the highest court of record of any other state, if attorneys licensed in Washington are permitted to appear before the courts of such other state in a representative capacity, and if not otherwise prohibited by state law;

(d) Public officials in their official capacity;

(e) A duly authorized director, officer, or full-time employee of an individual firm, association, partnership, or corporation who appears for such firm, association, partnership, or corporation;

(f) Partners, joint venturers or trustees representing their respective partnerships, joint ventures, or trusts; and

(g) Other persons designated by a person to whom the proceedings apply.

(11 ~~8~~) A pharmacy benefit manager's response to an appeal submitted by a Washington small pharmacy that is denied, partially reimbursed, or untimely must include written documentation or notice to identify the exact corporate entity that received and processed the appeal. Such information must include, but is not limited to, the corporate entity's full and complete name, taxpayer identification number, and number assigned by the office of the insurance commissioner.

(12 ~~9~~) Health care benefit managers providing pharmacy benefit management services benefit managers must identify a pharmacy benefit manager employee who is the single point of contact for appeals, and must include the address, phone number, name of the contact person, and valid email address. This includes completing and submitting the form that the commissioner makes available for this purpose at www.insurance.wa.gov.

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, amended and recodified as § 284-180-505, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 48.02.220 and chapter 19.340 RCW. WSR 18-13-023, § 284-180-400, filed 6/8/18, effective 7/9/18. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-400, filed 12/20/16, effective 1/1/17.]

WAC 284-180-515 Use of brief adjudicative proceedings for appeals by network pharmacies to the commissioner. The commissioner has adopted the procedure for brief adjudicative proceedings provided in RCW 34.05.482 through 34.05.494 for actions involving a network pharmacy's appeal of a pharmacy benefit manager's reimbursement for a drug ~~subject to predetermined reimbursement costs for multisource generic drugs (reimbursement)~~. WAC 284-180-500 through 284-180-540 describe the procedures for how the commissioner processes a network pharmacy's appeal (second tier appeal) of the pharmacy benefit manager's decision in the first tier appeal through a brief adjudicative proceeding.

This rule does not apply to adjudicative proceedings under WAC 284-02-070, including converted brief adjudicative proceedings.

[Statutory Authority: RCW 48.02.060, 48.200.280(6), 34.05.485 (1)(c), and 48.02.100. WSR 22-23-069 (Matter R 2022-07), § 284-180-515, filed 11/10/22, effective 12/11/22. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, amended and recodified as § 284-180-515, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-410, filed 12/20/16, effective 1/1/17.]

WAC 284-180-520 Appeals by network pharmacies to the commissioner. The following procedure applies to brief adjudicative proceedings before the commissioner for actions involving a network pharmacy's appeal of a pharmacy benefit manager's decision in a first tier appeal regarding reimbursement for a drug ~~subject to predetermined reimbursement costs for multisource generic drugs~~, unless the matter is converted to a formal proceeding as provided in WAC 284-180-540(3).

(1) **Grounds for appeal.** A network pharmacy or its representative may appeal a pharmacy benefit manager's decision to the commissioner if it meets all the following requirements:

(a) The pharmacy benefit manager's decision must have denied the network pharmacy's appeal, or the network pharmacy must be unsatisfied with the outcome of its appeal to the pharmacy benefit manager;

(b) The network pharmacy must request review of the pharmacy benefit manager's decision by submitting a petition at www.insurance.wa.gov according to the filing instructions.

The petition for review must include:

(i) The network pharmacy's basis for appealing the pharmacy benefit manager's decision in the first tier appeal;

(ii) The network pharmacy's business address and mailing address; and

(iii) Documents supporting the appeal;

(c) Documents supporting the appeal include:

(i) The documents from the first tier review, including the documents that the pharmacy submitted to the pharmacy benefit manager as well as the documents that the pharmacy benefit

manager provided to the pharmacy in response to the first tier review, if any (if the pharmacy benefit manager has not issued a decision on the first tier appeal in a timely manner, a signed attestation to that fact must be submitted by the appealing pharmacy);

(ii) Documentation evidencing the net amount paid for the drug by the small pharmacy;

(iii) If the first-tier appeal was denied by the pharmacy benefit manager because a therapeutically equivalent drug was available in the state of Washington at a price less than or equal to the ~~predetermined~~ reimbursement cost for the ~~multisource generic~~ drug and documentation provided by the pharmacy benefit manager evidencing the national drug code of the therapeutically equivalent drug; and

(iv) Any additional information that the commissioner may require;

(d) The network pharmacy must file the petition for review with the commissioner within 30 days of receipt of the pharmacy benefit manager's decision or within 30 days after the deadline

for the pharmacy benefit manager's deadline for responding to the first tier appeal;

(e) The network pharmacy making the appeal must have less than 15 retail outlets within the state of Washington under its corporate umbrella. The petition for review that the network pharmacy submits to the commissioner must include a signed attestation that this requirement is satisfied; and

(f) Electronic signatures and electronic records may be used to facilitate electronic transactions consistent with the Uniform Electronic Transactions Act chapter 1.80 RCW.

(2) **Time frames governing appeals to the commissioner.** The commissioner must complete the appeal within 30 calendar days of the receipt of the network pharmacy's complete petition for review. A complete petition for review means that all requirements under (1) of this subsection have been satisfied, including the submission of all required documents and documentation. An appeal before the commissioner is deemed complete when a presiding officer issues an initial order on behalf of the commissioner to both the network pharmacy and pharmacy benefit manager under subsection (8) of this section.

Within seven calendar days of the resolution of a dispute, the presiding officer shall provide a copy of the initial order to both the network pharmacy and pharmacy benefit manager.

(3) **Relief the commissioner may provide.** The commissioner, by and through a presiding officer or reviewing officer, may enter an order directing the pharmacy benefit manager to make an adjustment to the disputed claim, denying the network pharmacy's appeal, issuing civil penalties pursuant to RCW 48.200.290, or taking other actions deemed fair and equitable.

(4) **Notice.** If the presiding officer under the use of discretion chooses to conduct an oral hearing, the presiding officer will set the time and place of the hearing. Written notice shall be served upon both the network pharmacy and pharmacy benefit manager at least seven days before the date of the hearing. Service is to be made pursuant to WAC 284-180-440(2). The notice must include:

(a) The names and addresses of each party to whom the proceedings apply and, if known, the names and addresses of any representatives of such parties;

(b) The official file or other reference number and name of the proceeding, if applicable;

(c) The name, official title, mailing address and telephone number of the presiding officer, if known;

(d) A statement of the time, place and nature of the proceeding;

(e) A statement of the legal authority and jurisdiction under which the hearing is to be held;

(f) A reference to the particular sections of the statutes or rules involved;

(g) A short and plain statement of the matters asserted by the network pharmacy against the pharmacy benefit manager and the potential action to be taken; and

(h) A statement that if either party fails to attend or participate in a hearing, the hearing can proceed and the presiding or reviewing officer may take adverse action against that party.

(5) **Appearance and practice at a brief adjudicative proceeding.** The right to practice before the commissioner in a brief adjudicative proceeding is limited to:

(a) Persons who are natural persons representing themselves;

(b) Attorneys at law duly qualified and entitled to practice in the courts of the state of Washington;

(c) Attorneys at law entitled to practice before the highest court of record of any other state, if attorneys licensed in Washington are permitted to appear before the courts of such other state in a representative capacity, and if not otherwise prohibited by state law;

(d) Public officials in their official capacity;

(e) A duly authorized director, officer, or full-time employee of an individual firm, association, partnership, or corporation who appears for such firm, association, partnership, or corporation;

(f) Partners, joint venturers or trustees representing their respective partnerships, joint ventures, or trusts; and

(g) Other persons designated by a person to whom the proceedings apply with the approval of the presiding officer.

In the event a proceeding is converted from a brief adjudicative proceeding to a formal proceeding, representation is limited to the provisions of law and RCW 34.05.428.

(6) **Method of response.** Upon receipt of any inquiry from the commissioner concerning a network pharmacy's appeal of a pharmacy benefit manager's decision in the first tier appeal regarding reimbursement for a drug~~ subject to predetermined reimbursement costs for multisource generic drugs~~, pharmacy benefit managers must respond to the commissioner using the commissioner's electronic pharmacy appeals system.

(7) **Hearings by telephone.** If the presiding officer chooses to conduct a hearing, then the presiding officer may choose to conduct the hearing telephonically. The conversation will be recorded and will be part of the record of the hearing.

(8) **Presiding officer.**

(a) Per RCW 34.05.485, the presiding officer may be the commissioner, one or more other persons designated by the commissioner per RCW 48.02.100, or one or more other administrative law judges employed by the office of administrative hearings. The commissioner's choice of presiding

officer is entirely discretionary and subject to change at any time. However, it must not violate RCW 34.05.425 or 34.05.458.

(b) The presiding officer shall conduct the proceeding in a just and fair manner. Before taking action, the presiding officer shall provide both parties the opportunity to be informed of the presiding officer's position on the pending matter and to explain their views of the matter. During the course of the proceedings before the presiding officer, the parties may present all relevant information.

(c) The presiding officer may request additional evidence from either party at any time during review of the initial order. After the presiding officer requests evidence from a party, the party has seven days after service of the request to supply the evidence to the presiding officer, unless the presiding officer, under the use of discretion, allows additional time to submit the evidence.

(d) The presiding officer has all authority granted under chapter 34.05 RCW.

(9) **Entry of orders.**

(a) When the presiding officer issues a decision, the presiding officer shall briefly state the basis and legal authority for the decision. Within 10 days of issuing the decision, the presiding officer shall serve upon the parties the initial order, as well as information regarding any administrative review that may be available before the commissioner. The presiding officer's issuance of a decision within the 10-day time frame satisfies the seven day requirement in subsection (2) of this section.

(b) The initial order consists of the decision and the brief written statement of the basis and legal authority. The initial order will become a final order if neither party requests a review as provided in WAC 284-180-530(1).

(10) **Filing instructions.** When a small pharmacy or a pharmacy benefit manager provides information to the commissioner regarding appeals under WAC 284-180-520, the small pharmacy or pharmacy benefit manager must follow the commissioner's filing instructions, which are available at www.insurance.wa.gov.

[Statutory Authority: RCW 48.02.060, 48.200.280(6), 34.05.485 (1)(c), and 48.02.100. WSR 22-23-069 (Matter R 2022-07), § 284-180-520, filed 11/10/22, effective 12/11/22. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, amended and recodified as § 284-180-520, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 48.02.220 and chapter 19.340 RCW. WSR 18-13-023, § 284-180-420, filed 6/8/18, effective 7/9/18. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-420, filed 12/20/16, effective 1/1/17.]