

CERTIFICATION OF ENROLLMENT

**ENGROSSED SECOND SUBSTITUTE SENATE BILL 5213**

Chapter 242, Laws of 2024

68th Legislature  
2024 Regular Session

HEALTH CARE BENEFIT MANAGERS

EFFECTIVE DATE: June 6, 2024—Except for sections 5 and 7 through 9,  
which take effect January 1, 2026.

Passed by the Senate March 4, 2024  
Yeas 45 Nays 4

DENNY HECK

**President of the Senate**

Passed by the House February 29, 2024  
Yeas 73 Nays 20

Laurie Jinkins

**Speaker of the House of  
Representatives**

Approved March 25, 2024 2:05 PM

JAY INSLEE

**Governor of the State of Washington**

CERTIFICATE

I, Sarah Bannister, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SECOND SUBSTITUTE SENATE BILL 5213** as passed by the Senate and the House of Representatives on the dates hereon set forth.

SARAH BANNISTER

**Secretary**

FILED

March 26, 2024

**Secretary of State  
State of Washington**

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**ENGROSSED SECOND SUBSTITUTE SENATE BILL 5213**

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AS AMENDED BY THE HOUSE

Passed Legislature - 2024 Regular Session

**State of Washington**

**68th Legislature**

**2023 Regular Session**

**By** Senate Ways & Means (originally sponsored by Senators Kuderer, Short, Cleveland, Conway, Dhingra, Rolfes, Wellman, and C. Wilson)

READ FIRST TIME 02/24/23.

1 AN ACT Relating to health care benefit managers; amending RCW  
2 48.200.020, 48.200.030, 48.200.050, 48.200.210, and 48.200.280;  
3 reenacting and amending RCW 41.05.017; adding new sections to chapter  
4 48.200 RCW; and providing an effective date.

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

6 **Sec. 1.** RCW 48.200.020 and 2020 c 240 s 2 are each amended to  
7 read as follows:

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

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

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

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

18 (4)(a) "Health care benefit manager" means a person or entity  
19 providing services to, or acting on behalf of, a health carrier or  
20 employee benefits programs, that directly or indirectly impacts the  
21 determination or utilization of benefits for, or patient access to,

1 health care services, drugs, and supplies including, but not limited  
2 to:

- 3 (i) Prior authorization or preauthorization of benefits or care;
- 4 (ii) Certification of benefits or care;
- 5 (iii) Medical necessity determinations;
- 6 (iv) Utilization review;
- 7 (v) Benefit determinations;
- 8 (vi) Claims processing and repricing for services and procedures;
- 9 (vii) Outcome management;
- 10 (viii) (~~Provider credentialing and recredentialing;~~
- 11 ~~(ix)~~) Payment or authorization of payment to providers and
- 12 facilities for services or procedures;
- 13 (~~(x)~~) (ix) Dispute resolution, grievances, or appeals relating
- 14 to determinations or utilization of benefits;
- 15 (~~(xi)~~) (x) Provider network management; or
- 16 (~~(xii)~~) (xi) Disease management.

17 (b) "Health care benefit manager" includes, but is not limited  
18 to, health care benefit managers that specialize in specific types of  
19 health care benefit management such as pharmacy benefit managers,  
20 radiology benefit managers, laboratory benefit managers, and mental  
21 health benefit managers.

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

- 23 (i) Health care service contractors as defined in RCW 48.44.010;
- 24 (ii) Health maintenance organizations as defined in RCW
- 25 48.46.020;
- 26 (iii) Issuers as defined in RCW 48.01.053;
- 27 (iv) The public employees' benefits board established in RCW
- 28 41.05.055;
- 29 (v) The school employees' benefits board established in RCW
- 30 41.05.740;
- 31 (vi) Discount plans as defined in RCW 48.155.010;
- 32 (vii) Direct patient-provider primary care practices as defined
- 33 in RCW 48.150.010;
- 34 (viii) An employer administering its employee benefit plan or the
- 35 employee benefit plan of an affiliated employer under common
- 36 management and control;
- 37 (ix) A union, either on its own or jointly with an employer,
- 38 administering a benefit plan on behalf of its members;
- 39 (x) An insurance producer selling insurance or engaged in related
- 40 activities within the scope of the producer's license;

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

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

7 (xiii) A hospital licensed under chapter 70.41 RCW or ambulatory  
8 surgical facility licensed under chapter 70.230 RCW, to the extent  
9 that it performs provider credentialing or recredentialing, but no  
10 other functions of a health care benefit manager as described in  
11 subsection (4)(a) of this section;

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

13 (xv) The health technology clinical committee established under  
14 RCW 70.14.090; ~~((~~or~~))~~

15 (xvi) The prescription drug purchasing consortium established  
16 under RCW 70.14.060; or

17 (xvii) Any other entity that performs provider credentialing or  
18 recredentialing, but no other functions of a health care benefit  
19 manager as described in subsection (4)(a) of this section.

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

22 (6) "Health care service" has the same meaning as in RCW  
23 48.43.005.

24 (7) "Health carrier" or "carrier" has the same meaning as in RCW  
25 48.43.005.

26 (8) "Laboratory benefit manager" means a person or entity  
27 providing service to, or acting on behalf of, a health carrier,  
28 employee benefits programs, or another entity under contract with a  
29 carrier, that directly or indirectly impacts the determination or  
30 utilization of benefits for, or patient access to, health care  
31 services, drugs, and supplies relating to the use of clinical  
32 laboratory services and includes any requirement for a health care  
33 provider to submit a notification of an order for such services.

34 (9) "Mental health benefit manager" means a person or entity  
35 providing service to, or acting on behalf of, a health carrier,  
36 employee benefits programs, or another entity under contract with a  
37 carrier, that directly or indirectly impacts the determination of  
38 utilization of benefits for, or patient access to, health care  
39 services, drugs, and supplies relating to the use of mental health

1 services and includes any requirement for a health care provider to  
2 submit a notification of an order for such services.

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

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

9 (12)(a) "Pharmacy benefit manager" means a person that contracts  
10 with pharmacies on behalf of (~~(an insurer, a third-party payor, or~~  
11 ~~the prescription drug purchasing consortium established under RCW~~  
12 ~~70.14.060)~~) a health carrier, employee benefits program, or medicaid  
13 managed care program to:

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

16 (ii) Pay pharmacies or pharmacists for prescription drugs or  
17 medical supplies;

18 (iii) Negotiate rebates, discounts, or other price concessions  
19 with manufacturers for drugs paid for or procured as described in  
20 this subsection;

21 (iv) (~~Manage~~) Establish or manage pharmacy networks; or

22 (v) Make credentialing determinations.

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

25 (13)(a) "Radiology benefit manager" means any person or entity  
26 providing service to, or acting on behalf of, a health carrier,  
27 employee benefits programs, or another entity under contract with a  
28 carrier, that directly or indirectly impacts the determination or  
29 utilization of benefits for, or patient access to, the services of a  
30 licensed radiologist or to advanced diagnostic imaging services  
31 including, but not limited to:

32 (i) Processing claims for services and procedures performed by a  
33 licensed radiologist or advanced diagnostic imaging service provider;  
34 or

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

38 (b) "Radiology benefit manager" does not include a health care  
39 service contractor as defined in RCW 48.44.010, a health maintenance

1 organization as defined in RCW 48.46.020, or an issuer as defined in  
2 RCW 48.01.053.

3 (14) "Utilization review" has the same meaning as in RCW  
4 48.43.005.

5 (15) "Covered person" has the same meaning as in RCW 48.43.005.

6 (16) "Mail order pharmacy" means a pharmacy that primarily  
7 dispenses prescription drugs to patients through the mail or common  
8 carrier.

9 (17) "Pharmacy network" means the pharmacies located in the state  
10 or licensed under chapter 18.64 RCW and contracted by a pharmacy  
11 benefit manager to dispense prescription drugs to covered persons.

12 **Sec. 2.** RCW 48.200.030 and 2020 c 240 s 3 are each amended to  
13 read as follows:

14 (1) To conduct business in this state, a health care benefit  
15 manager must register with the commissioner and annually renew the  
16 registration.

17 (2) To apply for registration with the commissioner under this  
18 section, a health care benefit manager must:

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

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

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

30 (iii) Any areas of specialty such as pharmacy benefit management,  
31 radiology benefit management, laboratory benefit management, mental  
32 health benefit management, or other specialty;

33 (iv) A copy of the health care benefit manager's certificate of  
34 registration with the Washington state secretary of state; and

35 ~~((iv))~~ (v) Any other information as the commissioner may  
36 reasonably require.

37 (b) Pay an initial registration fee and annual renewal  
38 registration fee as established in rule by the commissioner. The fees  
39 for each registration must be set by the commissioner in an amount

1 that ensures the registration, renewal, and oversight activities are  
2 self-supporting. If one health care benefit manager has a contract  
3 with more than one carrier, the health care benefit manager must  
4 complete only one application providing the details necessary for  
5 each contract.

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

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

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

14 (b) Has paid the required fees; and

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

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

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

26 **Sec. 3.** RCW 48.200.050 and 2020 c 240 s 5 are each amended to  
27 read as follows:

28 (1) Upon notifying a carrier or health care benefit manager of an  
29 inquiry or complaint filed with the commissioner pertaining to the  
30 conduct of a health care benefit manager identified in the inquiry or  
31 complaint, the commissioner must provide notice of the inquiry or  
32 complaint (~~concurrently~~) to the health care benefit manager  
33 (~~and~~). Notice must also be sent to any carrier to which the inquiry  
34 or complaint pertains. The commissioner shall respond to and  
35 investigate complaints related to the conduct of a health care  
36 benefit manager subject to this chapter directly, without requiring  
37 that the complaint be pursued exclusively through a contracting  
38 carrier.

1 (2) Upon receipt of an inquiry from the commissioner, a health  
2 care benefit manager must provide to the commissioner within fifteen  
3 business days, in the form and manner required by the commissioner, a  
4 complete response to that inquiry including, but not limited to,  
5 providing a statement or testimony, producing its accounts, records,  
6 and files, responding to complaints, or responding to surveys and  
7 general requests. Failure to make a complete or timely response  
8 constitutes a violation of this chapter.

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

12 (a) Violated any provision of this chapter or insurance law, or  
13 violated any rule, subpoena, or order of the commissioner or of  
14 another state's insurance commissioner;

15 (b) Failed to renew the health care benefit manager's  
16 registration;

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

18 (d) Provided incorrect, misleading, incomplete, or materially  
19 untrue information to the commissioner, to a carrier, or to a  
20 beneficiary;

21 (e) Used fraudulent, coercive, or dishonest practices, or  
22 demonstrated incompetence, or financial irresponsibility in this  
23 state or elsewhere; or

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

27 the commissioner may take any combination of the following actions  
28 against a health care benefit manager or any person responsible for  
29 the conduct of the health care benefit manager's affairs, other than  
30 an employee benefits program:

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

33 (ii) Issue a cease and desist order against the health care  
34 benefit manager (~~and~~), contracting carrier, or both;

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

38 (iv) Issue an order requiring corrective action against the  
39 health care benefit manager, the contracting carrier acting with the  
40 health care benefit manager, or both the health care benefit manager



1 and the contracting carrier acting with the health care benefit  
2 manager; and

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

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

14 (5)(a) Health carriers and employee benefits programs are  
15 responsible for the compliance of any person or organization acting  
16 directly or indirectly on behalf of or at the direction of the  
17 carrier or program, or acting pursuant to carrier or program  
18 standards or requirements concerning the coverage of, payment for, or  
19 provision of health care benefits, services, drugs, and supplies.

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

24 (c) No carrier or program may offer as a defense to a violation  
25 of any provision of this chapter that the violation arose from the  
26 act or omission of a health care benefit manager, or other person  
27 acting on behalf of or at the direction of the carrier or program,  
28 rather than from the direct act or omission of the carrier or  
29 program.

30 **Sec. 4.** RCW 48.200.210 and 2020 c 240 s 10 are each amended to  
31 read as follows:

32 The definitions in this section apply throughout this section and  
33 RCW 48.200.220 through 48.200.290 unless the context clearly requires  
34 otherwise.

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

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

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

2 (a) In the keeping, recording, or transcribing of records or  
3 documents or in the handling of electronic or hard copies of  
4 correspondence;

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

6 (c) That does not involve dispensing an incorrect dose, amount,  
7 or type of medication, failing to dispense a medication, or  
8 dispensing a prescription drug to the wrong person.

9 (4) "Entity" includes:

10 (a) A pharmacy benefit manager;

11 (b) An insurer;

12 (c) A third-party payor;

13 (d) A state agency; or

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

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

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

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

24 (8) "Third-party payor" means a person licensed under RCW  
25 48.39.005.

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

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

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

36 (b) "Multiple source drug" means ((a therapeutically equivalent  
37 drug that is available from at least two manufacturers)) any covered  
38 outpatient prescription drug for which there is at least one other  
39 drug product that is rated as therapeutically equivalent under the

1 food and drug administration's most recent publication of "Approved  
2 Drug Products with Therapeutic Equivalence Evaluations"; is  
3 pharmaceutically equivalent or bioequivalent, as determined by the  
4 food and drug administration; and is sold or marketed in the state.

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

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

16 ~~((e))~~ (d) "Therapeutically equivalent" has the same meaning as  
17 in RCW 69.41.110.

18 (2) A pharmacy benefit manager:

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

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

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

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

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

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

1 (g) Shall ensure that dispensing fees are not included in the  
2 calculation of the (~~predetermined~~) reimbursement costs for  
3 (~~multisource-generic~~) multiple source drugs;

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

7 (i) May not charge a pharmacy a fee related to the adjudication  
8 of a claim, credentialing, participation, certification,  
9 accreditation, or enrollment in a network including, but not limited  
10 to, a fee for the receipt and processing of a pharmacy claim, for the  
11 development or management of claims processing services in a pharmacy  
12 benefit manager network, or for participating in a pharmacy benefit  
13 manager network, and may not condition or link restrictions on fees  
14 related to credentialing, participation, certification, or enrollment  
15 in a pharmacy benefit manager's pharmacy network with a pharmacy's  
16 inclusion in the pharmacy benefit manager's pharmacy network for  
17 other lines of business;

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

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

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

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

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

30 (m) May not exclude a pharmacy from their pharmacy network based  
31 solely on the pharmacy being newly opened or open less than a defined  
32 amount of time, or because a license or location transfer occurs,  
33 unless there is a pending investigation for fraud, waste, and abuse.

34 (3) A pharmacy benefit manager must establish a process by which  
35 a network pharmacy, or its representative, may appeal its  
36 reimbursement for a drug (~~(subject to predetermined reimbursement~~  
37 ~~costs for multisource-generic drugs)~~). A network pharmacy may appeal  
38 a (~~predetermined reimbursement cost~~) reimbursement amount paid by a  
39 pharmacy benefit manager for a (~~multisource-generic~~) drug if the  
40 reimbursement for the drug is less than the net amount that the

1 network pharmacy paid to the supplier of the drug. An appeal  
2 requested under this section must be completed within thirty calendar  
3 days of the pharmacy submitting the appeal. If after thirty days the  
4 network pharmacy has not received the decision on the appeal from the  
5 pharmacy benefit manager, then the appeal is considered denied.

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

13 (4) Before a pharmacy or pharmacist files an appeal pursuant to  
14 this section, upon request by a pharmacy or pharmacist, a pharmacy  
15 benefit manager must provide a current and accurate list of bank  
16 identification numbers, processor control numbers, and pharmacy group  
17 identifiers for health plans and self-funded group health plans that  
18 have opted in to sections 5, 7, and 8 of this act pursuant to section  
19 9 of this act with which the pharmacy benefit manager either has a  
20 current contract or had a contract that has been terminated within  
21 the past 12 months to provide pharmacy benefit management services.

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

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

27 (b) If the appeal is denied, the reason for the denial and the  
28 national drug code of a drug that has been purchased by other network  
29 pharmacies located in Washington at a price that is equal to or less  
30 than the ~~((predetermined))~~ reimbursement ~~((cost))~~ amount paid by the  
31 pharmacy benefit manager for the ~~((multisource-generie))~~ drug. A  
32 pharmacy with ~~((fifteen))~~ 15 or more retail outlets, within the state  
33 of Washington, under its corporate umbrella may submit information to  
34 the commissioner about an appeal under subsection (3) of this section  
35 for purposes of information collection and analysis.

36 ~~((+5))~~ (6) (a) If an appeal is upheld under this section, the  
37 pharmacy benefit manager shall make a reasonable adjustment on a date  
38 no later than one day after the date of determination.

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

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

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

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

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

19 (c) The commissioner may authorize the office of administrative  
20 hearings, as provided in chapter 34.12 RCW, to conduct appeals under  
21 this subsection ~~((+6))~~ (7).

22 (d) A pharmacy benefit manager may not retaliate against a  
23 pharmacy for pursuing an appeal under this subsection ~~((+6))~~ (7).

24 (e) This subsection ~~((+6))~~ (7) applies only to a pharmacy with  
25 fewer than fifteen retail outlets, within the state of Washington,  
26 under its corporate umbrella.

27 ~~((+7))~~ (8) This section does not apply to the state medical  
28 assistance program.

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

31 (1) Each health care benefit manager must appoint the  
32 commissioner as its attorney to receive service of, and upon whom  
33 must be served, all legal process issued against it in this state for  
34 causes of action arising within this state. Service upon the  
35 commissioner as attorney constitutes service upon the health care  
36 benefit manager. Service of legal process against the health care  
37 benefit manager can be had only by service upon the commissioner,  
38 except actions upon contractor bonds pursuant to RCW 18.27.040, where  
39 service may be upon the department of labor and industries.

1 (2) With the appointment the health care benefit manager must  
2 designate by name, email address, and address the person to whom the  
3 commissioner must forward legal process so served upon them. The  
4 health care benefit manager may change the person by filing a new  
5 designation.

6 (3) The health care benefit manager must keep the designation,  
7 address, and email address filed with the commissioner current.

8 (4) The appointment of the commissioner as attorney is  
9 irrevocable, binds any successor in interest or to the assets or  
10 liabilities of the health care benefit manager, and remains in effect  
11 as long as there is in force in this state any contract made by the  
12 health care benefit manager or liabilities or duties arising  
13 therefrom.

14 (5) The service of process must be accomplished and processed in  
15 the manner prescribed under RCW 48.02.200.

16 NEW SECTION. **Sec. 7.** A new section is added to chapter 48.200  
17 RCW to read as follows:

18 (1) A pharmacy benefit manager may not:

19 (a) Reimburse a network pharmacy an amount less than the contract  
20 price between the pharmacy benefit manager and the insurer, third-  
21 party payor, or the prescription drug purchasing consortium the  
22 pharmacy benefit manager has contracted with;

23 (b) Require a covered person to pay more at the point of sale for  
24 a covered prescription drug than is required under RCW 48.43.430; or

25 (c) Require or coerce a patient to use their owned or affiliated  
26 pharmacies.

27 (2) A pharmacy benefit manager shall:

28 (a) Apply the same utilization review, fees, days allowance, and  
29 other conditions upon a covered person when the covered person  
30 obtains a prescription drug from a pharmacy that is included in the  
31 pharmacy benefit manager's pharmacy network, including mail order  
32 pharmacies;

33 (b) Permit the covered person to receive delivery or mail order  
34 of a prescription drug through any network pharmacy that is not  
35 primarily engaged in dispensing prescription drugs to patients  
36 through the mail or common carrier; and

37 (c) For new prescriptions issued after the effective date of this  
38 section, receive affirmative authorization from a covered person  
39 before filling prescriptions through a mail order pharmacy.

1 (3) If a covered person is using a mail order pharmacy, the  
2 pharmacy benefit manager shall:

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

6 (i) If the prescription is delayed more than one day after the  
7 expected delivery date provided by the mail order pharmacy; or

8 (ii) If the prescription drug arrives in an unusable condition;  
9 and

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

12 NEW SECTION. **Sec. 8.** A new section is added to chapter 48.200  
13 RCW to read as follows:

14 (1) A pharmacy benefit manager may not retaliate against a  
15 pharmacist or pharmacy for disclosing information in a court, in an  
16 administrative hearing, or legislative hearing, if the pharmacist or  
17 pharmacy has a good faith belief that the disclosed information is  
18 evidence of a violation of a state or federal law, rule, or  
19 regulation.

20 (2) A pharmacy benefit manager may not retaliate against a  
21 pharmacist or pharmacy for disclosing information to a government or  
22 law enforcement agency, if the pharmacist or pharmacy has a good  
23 faith belief that the disclosed information is evidence of a  
24 violation of a state or federal law, rule, or regulation.

25 (3) A pharmacist or pharmacy shall make reasonable efforts to  
26 limit the disclosure of confidential and proprietary information.

27 (4) Retaliatory actions against a pharmacy or pharmacist include  
28 cancellation of, restriction of, or refusal to renew or offer a  
29 contract to a pharmacy solely because the pharmacy or pharmacist has:

30 (a) Made disclosures of information that the pharmacist or  
31 pharmacy believes is evidence of a violation of a state or federal  
32 law, rule, or regulation;

33 (b) Filed complaints with the plan or pharmacy benefit manager;  
34 or

35 (c) Filed complaints against the plan or pharmacy benefit manager  
36 with the commissioner.

37 NEW SECTION. **Sec. 9.** A new section is added to chapter 48.200  
38 RCW to read as follows:



1 (1) Nothing in this act expands or restricts the entities subject  
2 to this chapter. Therefore, except as provided in subsection (2) of  
3 this section, this chapter continues to be inapplicable to a person  
4 or entity providing services to, or acting on behalf of, a union or  
5 employer administering a self-funded group health plan governed by  
6 the provisions of the federal employee retirement income security act  
7 of 1974 (29 U.S.C. Sec. 1001 et seq.).

8 (2) Sections 5, 7, and 8 of this act apply to a pharmacy benefit  
9 manager's conduct pursuant to a contract with a self-funded group  
10 health plan governed by the provisions of the federal employee  
11 retirement income security act of 1974 (29 U.S.C. Sec. 1001 et seq.)  
12 only if the self-funded group health plan elects to participate in  
13 sections 5, 7, and 8 of this act. To elect to participate in these  
14 provisions, a self-funded group health plan or its administrator  
15 shall provide notice, on a periodic basis, to the commissioner in a  
16 manner and by a date prescribed by the commissioner, attesting to the  
17 plan's participation and agreeing to be bound by sections 5, 7, and 8  
18 of this act. A self-funded group health plan or its administrator  
19 that elects to participate under this section, and any pharmacy  
20 benefit manager it contracts with, shall comply with sections 5, 7,  
21 and 8 of this act.

22 (3) The commissioner does not have enforcement authority related  
23 to a pharmacy benefit manager's conduct pursuant to a contract with a  
24 self-funded group health plan governed by the federal employee  
25 retirement income security act of 1974, 29 U.S.C. Sec. 1001 et seq.,  
26 that elects to participate in sections 5, 7, and 8 of this act.

27 **Sec. 10.** RCW 41.05.017 and 2022 c 236 s 3, 2022 c 228 s 2, and  
28 2022 c 10 s 2 are each reenacted and amended to read as follows:

29 Each health plan that provides medical insurance offered under  
30 this chapter, including plans created by insuring entities, plans not  
31 subject to the provisions of Title 48 RCW, and plans created under  
32 RCW 41.05.140, are subject to the provisions of RCW 48.43.500,  
33 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545,  
34 48.43.550, 70.02.110, 70.02.900, 48.43.190, 48.43.083, 48.43.0128,  
35 48.43.780, 48.43.435, 48.43.815, 48.200.020 through 48.200.280,  
36 sections 6 through 8 of this act, and chapter 48.49 RCW.

37 NEW SECTION. **Sec. 11.** If any provision of this act or its  
38 application to any person or circumstance is held invalid, the

1 remainder of the act or the application of the provision to other  
2 persons or circumstances is not affected.

3 NEW SECTION. **Sec. 12.** Sections 5 and 7 through 9 of this act  
4 take effect January 1, 2026.

Passed by the Senate March 4, 2024.

Passed by the House February 29, 2024.

Approved by the Governor March 25, 2024.

Filed in Office of Secretary of State March 26, 2024.

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