Multiple Agency Fiscal Note Summary

Bill Number: 5213 E 2S SB	**Title:** Pharmacy benefit managers

Estimated Cash Receipts

NONE

Estimated Operating Expenditures

Agency Name	2023-25				2025-27				2027-29			
	FTEs	GF-State	NGF-Outlook	Total	FTEs	GF-State	NGF-Outlook	Total	FTEs	GF-State	NGF-Outlook	Total
Washington State Health Care Authority	Fiscal note not available											
Office of Insurance Commissioner	.5	0	0	174,510	3.7	0	0	1,108,640	2.8	0	0	819,420
Total $	**0.5**	**0**	**0**	**174,510**	**3.7**	**0**	**0**	**1,108,640**	**2.8**	**0**	**0**	**819,420**

Estimated Capital Budget Expenditures

Agency Name	2023-25			2025-27			2027-29		
	FTEs	Bonds	Total	FTEs	Bonds	Total	FTEs	Bonds	Total
Washington State Health Care Authority	Fiscal note not available								
Office of Insurance Commissioner	.0	0	0	.0	0	0	.0	0	0
Total $	**0.0**	**0**	**0**	**0.0**	**0**	**0**	**0.0**	**0**	**0**

Estimated Capital Budget Breakout

NONE

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FNPID 71046

FNS029 Multi Agency rollup

Individual State Agency Fiscal Note

Bill Number: 5213 E 2S SB	Title: Pharmacy benefit managers	Agency: 160-Office of Insurance Commissioner

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

NONE

Estimated Operating Expenditures from:

	FY 2024	FY 2025	2023-25	2025-27	2027-29
FTE Staff Years	0.0	1.0	0.5	3.7	2.8
Account					
Insurance Commissioners Regulatory Account-State 138-1	0	174,510	174,510	1,108,640	819,420
Total $	0	174,510	174,510	1,108,640	819,420

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☒ Requires new rule making, complete Part V.

Legislative Contact:	Sandy Stith	Phone: 786-7710	Date: 02/13/2024
Agency Preparation:	Jane Beyer	Phone: 360-725-7043	Date: 02/19/2024
Agency Approval:	Michael Wood	Phone: 360-725-7007	Date: 02/19/2024
OFM Review:	Jason Brown	Phone: (360) 742-7277	Date: 02/21/2024

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Significant provisions of the bill and any related workload or policy assumptions that have revenue or expenditure impact on the responding agency by section number.

Section 3(1) requires the Office of Insurance Commissioner (OIC) to respond to and investigate complaints related to the conduct of a Health Care Benefit Manager (HCBM) directly, without requiring that the complaint be pursued exclusively through a contracting carrier.

Section 5(2)(i) prohibits a Pharmacy Benefit Manager (PBM) from conditioning or linking restrictions on fees related to credentialing, participation, certification, or enrollment in a PBM's pharmacy network with a pharmacy's inclusion in the PBM's pharmacy network for other lines of business.

Section 5(2)(m) prohibits a PBM from excluding a pharmacy from their pharmacy network based solely on the pharmacy being newly opened or open less than a defined amount of time, or because a license or location transfer occurs, unless there is a pending investigation for fraud, waste, and abuse.

Section 5(3) allows a network pharmacy to appeal a reimbursement amount paid by a pharmacy benefit manager for a drug if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug.

Section 7(1) prohibits PBMs from reimbursing a network pharmacy less than the contract price between the PBM and the insurer, third-party payor, or the prescription drug purchasing consortium the PBM has contracted with; from requiring a covered person to pay more at the point of sale for a covered prescription drug than is required under RCW 48.43.430; or from soliciting, coercing, or incentivizing a patient to use their owned or affiliated pharmacies.

Section 7(2) requires PBMs to apply the same cost-sharing amounts, fees, days allowance, and other conditions upon a covered person when the covered person obtains a prescription drug from a pharmacy that is included in the PBM's pharmacy network, including mail order pharmacies; to permit the covered person to receive delivery or mail order of a prescription drug through any network pharmacy that is not primarily engaged in dispensing prescription drugs to patients through the mail or common carriers; and for new prescriptions, to receive affirmative authorization from a covered person before filing prescriptions through a mail order pharmacy.

Section 7(3) requires PBMs, if a covered person is using a mail order pharmacy, to allow for dispensing at local network pharmacies if the prescription is delayed more than one day after the expected delivery date provided by the mail order pharmacy or if the prescription drug arrives in an unusable condition; and to ensure patients have easy and timely access to prescription counseling by a pharmacist.

Section 8(2) prohibits a PBM from retaliating against a pharmacist or pharmacy for disclosing information to a government of law enforcement agency if the pharmacist or pharmacy has a good faith belief that the disclosed information is evidence of a violation of a state or federal law, rule, or regulation. Retaliatory actions against a pharmacy or pharmacist include cancellation of, restriction of, or refusal to renew or offer a contract to a pharmacy solely because the pharmacy or pharmacist has disclosed information and or filed complaints with or against the plan or PBM.

Section 9 applies sections 5, 7, and 8 to a PBM's conduct pursuant to a contract with a self-funded group health plan governed by the provisions of the federal Employee Retirement Income Security Act (ERISA) only if the self-funded group health plan elects to participate in sections 5, 7, and 8. To elect to participate in these provisions, a self-funded group health plan or its administrator must provide notice, on a periodic basis, to the OIC in a manner and by a date prescribed by the OIC, attesting to the plan's participation and agreeing to be bound by sections 5, 7, and 8. The OIC does not have enforcement authority over this section.

Section 12 directs that sections 5 and 7 through 9 are effective January 1, 2026.

II. B - Cash receipts Impact

Cash receipts impact of the legislation on the responding agency with the cash receipts provisions identified by section number and when appropriate, the detail of the revenue sources. Description of the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explanation of how workload assumptions translate into estimates. Distinguished between one time and ongoing functions.

Under current law, once per year, based on legislative appropriation and fund balance, a registration renewal fee that is sufficient to cover Health Care Benefit Manager (HCBM) registering, renewing and oversight activities is set for the ensuing fiscal year. The OIC assumes no additional revenue impact as a result of this bill. However, an increase in appropriation will result in a corresponding increase to HCBM renewal fees.

II. C - Expenditures

Agency expenditures necessary to implement this legislation (or savings resulting from this legislation), with the provisions of the legislation that result in the expenditures (or savings) identified by section number. Description of the factual basis of the assumptions and the method by which the expenditure impact is derived. Explanation of how workload assumptions translate into cost estimates. Distinguished between one time and ongoing functions.

Section 3(1) requires the Office of Insurance Commissioner (OIC) to respond to and investigate complaints related to the conduct of a Health Care Benefit Manager (HCBM) directly, without requiring that the complaint be pursued exclusively through a contracting carrier. Section 3(1) will drive additional written inquiries, calls and complaints to the OIC. Based on complaint data from 2022-2023, the OIC estimates an additional 92 phone calls and 46 complaints relating to the conduct of a HCBM will be received each year beginning in FY2025. Informational cases generally take 10 minutes per case and complaint cases generally take between 1.0 and 3.25 hours per case. For purposes of this fiscal note, it is assumed informational cases will require 10 minutes per case and complaint cases will require an average of 3.25 hours per case requiring 165 hours (92 info cases x 10 minutes + 46 complaint cases x 3.25 hours) of a Functional Program Analyst 3 (FPA3) beginning in FY2025. In addition, OIC anticipates one-time costs, in FY2025, of 50 hours of a Functional Program Analyst 4 to modify complaint procedures, train staff, and add new complaint paths to the OIC's Online Complaint Tool.

Section 5(2)(i) prohibits a Pharmacy Benefit Manager (PBM) from conditioning or linking restrictions on fees related to credentialing, participation, certification, or enrollment in a PBM's pharmacy network with a pharmacy's inclusion in the PBM's pharmacy network for other lines of business.

Section 5(2)(m) prohibits a PBM from excluding a pharmacy from their pharmacy network based solely on the pharmacy being newly opened or open less than a defined amount of time, or because a license or location transfer occurs, unless there is a pending investigation for fraud, waste, and abuse.

Section 5(2)'s new prohibitions will drive additional written inquiries and calls from pharmacists to the OIC. Based on the estimated number of pharmacists in WA (112,000 based on WA Pharmacy Association Survey Data) and the assumption that 1% of the pharmacists will contact the OIC with inquiries each year, the OIC estimates an additional 1,120 informational inquiries will be received each year beginning in FY2026. Informational cases generally take 10 minutes per case requiring 187 hours (1,120 informational cases x 10 minutes) of a FPA3 beginning in FY2026. In addition, OIC anticipates one-time costs in FY2026 of 8 hours of a FPA3 to create new webpages with educational information for pharmacies, pharmacists, and providers with information about their rights.

Section 5(3) allows a network pharmacy to appeal a reimbursement amount paid by a pharmacy benefit manager for a drug if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug. Based on the last two calendar years, the OIC sends an average of 35 pharmacy benefit manager related appeals to the Office of Administrative Hearings (OAH) each year. Section 5(3) will allow the appeal of reimbursement costs for all drugs, rather than only for multisource generic drugs, resulting in the expected number of reimbursement cost appeals sent to OAH to double. Based on existing appropriation received for Health Care Benefit Manager reimbursement appeals at OAH, the OIC can absorb the additional hearings costs through existing appropriation.

Section 7(1) prohibits PBMs from reimbursing a network pharmacy less than the contract price between the PBM and the insurer, third-party payor, or the prescription drug purchasing consortium the PBM has contracted with; from requiring a

covered person to pay more at the point of sale for a covered prescription drug than is required under RCW 48.43.430; or from soliciting, coercing, or incentivizing a patient to use their owned or affiliated pharmacies.

Section 7(2) requires PBMs to apply the same cost-sharing amounts, fees, days allowance, and other conditions upon a covered person when the covered person obtains a prescription drug from a pharmacy that is included in the PBM's pharmacy network, including mail order pharmacies; to permit the covered person to receive delivery or mail order of a prescription drug through any network pharmacy that is not primarily engaged in dispensing prescription drugs to patients through the mail or common carriers; and for new prescriptions, to receive affirmative authorization from a covered person before filing prescriptions through a mail order pharmacy.

Section 7(3) requires PBMs, if a covered person is using a mail order pharmacy, to allow for dispensing at local network pharmacies if the prescription is delayed more than one day after the expected delivery date provided by the mail order pharmacy or if the prescription drug arrives in an unusable condition; and to ensure patients have easy and timely access to prescription counseling by a pharmacist.

Section 7 will require the OIC to develop and apply a new review standard for pharmacy provider contracts and health plan form filings. All pharmacy provider contracts and health plan form filings must be reviewed to ensure that they are in compliance with the requirements of this section. The OIC receives approximately 175 pharmacy provider contracts and 502 health plan form filings each year and assumes the modified review criteria will result in an additional 30 minutes of review per pharmacy provider contract beginning in FY2026; and an additional 15 minutes of review per health form filing in FY2026, reduced to 5 minutes of review per health form filing beginning in FY2027 requiring 88 hours (175 provider contracts x 30 minutes) of a FPA3 beginning in FY2026; 126 hours (502 health form filings x 15 minutes) of a FPA3 in FY2026; and 42 hours (502 health form filings x 5 minutes) of a FPA3 in FY2027 and thereafter. The OIC will also require one-time costs, in FY2026, of 26 hours of a Functional Program Analyst 4 to update filing review standards, update checklist documents and filing instructions, and train staff.

Section 7 will generate an increase in complaints, calls and inquiries from pharmacies and pharmacists that believe they have not been reimbursed correctly or believe they have been excluded from a PBM network incorrectly; from consumers who believe they have paid more for their medications than required; and from consumers believing their health plan is not allowing their retail pharmacy to mail their prescription or that they are paying more than they used to pay for mail order prescriptions. In 2023, the OIC received 155 consumer complaints regarding pharmacy benefits based on NAIC CDS complaint coding and 8 complaints from pharmacies and pharmacists relating to PBMs. The OIC expects a 10% increase in this number of consumer complaints, and we expect that the number of pharmacy and pharmacist complaints will double with these new protections. Complaint cases generally take between 1.0 and 3.25 hours per case. For purposes of this fiscal note, it is assumed complaint cases will require an average of 3.25 hours per case requiring 130 hours (32 consumer complaints + 8 complaint cases x 3.25 hours) of a Functional Program Analyst 3 beginning in FY2026.

Section 8(2) prohibits a PBM from retaliating against a pharmacist or pharmacy for disclosing information to a government of law enforcement agency if the pharmacist or pharmacy has a good faith belief that the disclosed information is evidence of a violation of a state or federal law, rule, or regulation. Retaliatory actions against a pharmacy or pharmacist include cancellation of, restriction of, or refusal to renew or offer a contract to a pharmacy solely because the pharmacy or pharmacist has disclosed information and or filed complaints with or against the plan or PBM.

The provisions in Sections 3, 5, 6, 7 and 8 will result in an increase in enforcement cases, including investigations and enforcement actions, and hearing demands. OIC anticipates an additional 70 investigations with 23 cases being sent to hearings in FY2026, reduced to 40 investigations with 13 cases being sent to hearings each year beginning in FY2027. Investigations generally take anywhere between 25-80 hours per case and hearings generally take 50 hours per case. For purposes of this fiscal note, due to the complexity of the complaints, it is assumed that investigations will require an average of 80 hours per case and hearings will require an average of 50 hours per case requiring 5,600 hours (70 investigations x 80 hours) of an Investigator 3 and 1,150 hours (23 hearings x 50 hours) of an Insurance Attorney in FY2026 and 3,200 hours (40 investigations x 80 hours) of an Investigator 3 and 650 hours (13 hearings x 50 hours) of an Insurance Attorney in

FY2027 and thereafter. In addition, OIC anticipates one-time costs, in FY2026, of 75 hours of an Insurance Attorney to provide advice related to this statutory change and its interpretation, implementation and enforcement.

Section 9 applies sections 5, 7, and 8 to a PBM's conduct pursuant to a contract with a self-funded group health plan governed by the provisions of the federal Employee Retirement Income Security Act (ERISA) only if the self-funded group health plan elects to participate in sections 5, 7, and 8. To elect to participate in these provisions, a self-funded group health plan or its administrator must provide notice, on a periodic basis, to the OIC in a manner and by a date prescribed by the OIC, attesting to the plan's participation and agreeing to be bound by sections 5, 7, and 8. The OIC does not have enforcement authority over this section.

Section 9 will require the OIC to develop an opt-in process for self-funded group health plans and will generate an increase in complaints, calls and inquiries from pharmacies and pharmacists. In 2023, the OIC received 38 complaints regarding pharmacy benefits that were outside of the OIC's jurisdiction. Beginning in FY2026, the OIC expects 15% of these complaint cases will be from opted in health plans. Complaint cases generally take between 1.0 and 3.25 hours per case. For purposes of this fiscal note, it is assumed complaint cases will require an average of 3.25 hours per case requiring 20 hours (6 complaint cases x 3.25 hours) of a FPA3 beginning in FY2026. The OIC will also require one-time costs, in FY2026, of 30 hours of a Communications Consultant 4 to establish the opt-in process including updating OIC's webpage with information about the process.

Ongoing Costs:
Salary, benefits and associated costs for 1.98 FTE Investigator 3, .40 FTE Insurance Attorney, and .39 FTE Functional Program Analyst 3.

Part III: Expenditure Detail

III. A - Operating Budget Expenditures

Account	Account Title	Type	FY 2024	FY 2025	2023-25	2025-27	2027-29
138-1	Insurance Commissioners Regulatory Account	State	0	174,510	174,510	1,108,640	819,420
		Total $	0	174,510	174,510	1,108,640	819,420

III. B - Expenditures by Object Or Purpose

	FY 2024	FY 2025	2023-25	2025-27	2027-29
FTE Staff Years		1.0	0.5	3.7	2.8
A-Salaries and Wages		100,980	100,980	662,424	489,376
B-Employee Benefits		31,428	31,428	224,488	166,160
C-Professional Service Contracts					
E-Goods and Other Services		33,102	33,102	221,728	163,884
G-Travel					
J-Capital Outlays		9,000	9,000		
M-Inter Agency/Fund Transfers					
N-Grants, Benefits & Client Services					
P-Debt Service					
S-Interagency Reimbursements					
T-Intra-Agency Reimbursements					
9-					
Total $	0	174,510	174,510	1,108,640	819,420

III. C - Operating FTE Detail: *List FTEs by classification and corresponding annual compensation. Totals need to agree with total FTEs in Part I and Part IIIA*

Job Classification	Salary	FY 2024	FY 2025	2023-25	2025-27	2027-29
Communications Consultant 4	76,608				0.0	
Functional Program Analyst 3	78,468		0.1	0.1	0.4	0.4
Functional Program Analyst 4	86,712		0.2	0.1	0.0	
Insurance Attorney	95,652				0.6	0.4
Investigator 3	88,800				2.7	2.0
Senior Policy Analyst	116,148		0.7	0.3		
Total FTEs			1.0	0.5	3.7	2.8

III. D - Expenditures By Program (optional)

NONE

Part IV: Capital Budget Impact

IV. A - Capital Budget Expenditures

NONE

IV. B - Expenditures by Object Or Purpose

NONE

IV. C - Capital Budget Breakout

Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.

NONE

IV. D - Capital FTE Detail: *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.*

NONE

Part V: New Rule Making Required

Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.

'Complex' rulemaking, in FY2025, is required to implement this bill. Revisions, as well as new sections will be needed for Chap. 284-180 WAC. The complexity of the bill language and the number of interested parties involved will make this a complex rulemaking.