SENATE BILL REPORT
SB 6241

As of February 2, 2012

Title: An act relating to prescription drug benefits.

Brief Description: Limiting prescription drug cost-sharing obligations and out-of-pocket expenses.

Sponsors: Senators Pridemore, Keiser, Harper and Nelson.

Brief History:
Committee Activity: Health & Long-Term Care: 1/30/12.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Mich'l Needham (786-7442)

Background: The federal Affordable Care Act (ACA), passed in March 2010, requires health insurance coverage beginning in 2014 to have defined cost-sharing limits for the overall out-of-pocket maximum and a limit on the annual deductible. Cost-sharing includes deductibles, co-insurance, co-payments or similar charges. Cost-sharing does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services. The cost-sharing limitations contain an overall limitation on cost-sharing and a deductible limit.

For plan years beginning in 2014, group health insurance plans must have an annual deductible that cannot exceed $2,000 for a plan covering a single individual, or $4,000 for a plan covering more than one individual. The amounts may be adjusted annually by an index amount and adjustment for the percentage change in the average per capita premium for health insurance. The overall cost-sharing limitation or out-of-pocket maximum must be based on the maximum out-of-pocket expense limits for Health Savings Account compatible high deductible health plans (HDHPs) for taxable years beginning in 2014. The amount is adjusted annually for increases in cost of living, so the out-of-pocket expense limits for the HDHPs for 2014 are not currently available. For 2010 and 2011, the HDHP maximum out-of-pocket expense limit cannot exceed $5,950 for coverage for a single individual and $11,900 for family coverage.

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The ACA eliminated the use of lifetime limits effective September 2010, and allowed health plans issued prior to January 1, 2014, to include some annual limits on benefits for services within the essential health benefits definition, and allowed limitations on specific services.

Summary of Bill: Health insurance coverage offered or renewed on or after January 1, 2013, that provide coverage for prescription drugs must provide a single limit on out-of-pocket expenses in all the health plans. All out-of-pocket expenses for medical services, surgical services, mental health services, or prescription drugs must be included in the single limit. The out-of-pocket limit may not exceed $5,950 for coverage for a single individual, and $11,900 for coverage of more than one enrollee.

In July 2013 and every July thereafter, the Insurance Commissioner must adjust the out-of-pocket limits to reflect the percentage change in the consumer price index for medical care for the preceding 12 months.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: We have seen increasing costs for consumers, with thresholds so high that many people cannot meet their deductibles. But for those that have significant health needs, the prescription drug benefits can be out of reach, especially with the different limits today. New home treatments are available that keep people healthier and functioning better, but coverage limitations with prescription benefits really hit people. The good news is that many of these chronic diseases are treatable today, the bad news is the treatments are very expensive – thousands of dollars a month. For example, the medication for hemophilia is $1,000 a day. The policies mean we reach the limit for the year in the first few weeks.

CON: This bill moves some of the ACA language into early implementation, with different requirements in some areas that will require the carriers to make significant system changes for 2013, and then again for 2014. The prescription drug coverage is not mandated today, and that means the systems have the benefit components calculated separately as separate policy pieces. There is no system interface, and we will need to redesign the systems and benefits. The change will also drive up premium increases an estimated 4-8 percent, which may force many individuals and small businesses to drop the coverage entirely. There will be adverse cost impact since the limits are one of the main opportunities to control premium costs. Putting in some of the requirements before the ACA changes does not make sense – the pieces have critical interconnections.

OTHER: This accelerates the ACA change in out-of-pocket limits, but when it is done in the context of the ACA, the Washington market is not called out to do special and unique things that make it harder for business to offer products here. This will create a unique burden on Washington until the ACA requirements are in place. We also have the *NFIB vs. Sebelius*

case moving forward, and we would like to see how that is resolved. If this is considered, perhaps we should insert a sunset if the ACA is repealed or overturned.

Persons Testifying: PRO: Senator Pridemore, prime sponsor; Erin Dziedzic, American Cancer Society; Dr. Eugene May and Lenita Fryxell, National Multiple Sclerosis Society; Kristen McNulty and Stephanie Simpson, Bleeding Disorder Foundation; Heidi Barrett and Johanna Lindsay, Arthritis Foundation.

CON: Sydney Zvara, Assn. of WA Healthcare Plans; Mel Sorensen, Assn. of Health Insurance Plans.

OTHER: Patrick Connor, National Federation of Independent Business.