HOUSE BILL REPORT
HB 2319

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to prescription drug insurance continuity of care.

Brief Description: Concerning prescription drug insurance continuity of care.

Sponsors: Representatives Jinkins, DeBolt, Tharinger and Van De Wege.

Brief History:
Committee Activity:
Health Care & Wellness: 1/13/16, 1/15/16, 2/5/16 [DPS].

Brief Summary of Substitute Bill

- Requires individual market insurers to continue to cover prescription drugs for enrollees under certain circumstances.
- Prohibits individual market insurers from increasing copayment or coinsurance amounts for prescription drugs under certain circumstances.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 12 members: Representatives Cody, Chair; Riccelli, Vice Chair; Harris, Assistant Ranking Minority Member; Caldier, Clibborn, DeBolt, Jinkins, Johnson, Moeller, Robinson, Tharinger and Van De Wege.

Minority Report: Do not pass. Signed by 2 members: Representatives Schmick, Ranking Minority Member; Short.

Minority Report: Without recommendation. Signed by 1 member: Representative Rodne.

Staff: Jim Morishima (786-7191).

Background:

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

A health plan offering coverage to individuals or small groups is required, under the federal Patient Protection and Affordable Care Act (PPACA), to cover 10 categories of essential health benefits, one of which is prescription drugs. To comply with the PPACA's prescription drug coverage requirement, an issuer must cover prescription drugs in a manner substantially equal to a benchmark plan selected by the state. The issuer's formulary is part of the prescription drug category and must be substantially equal to the formulary in the benchmark plan. An issuer must file its formulary quarterly with the Office of the Insurance Commissioner.

Summary of Substitute Bill:

For plans issued or renewed on or after January 1, 2018, an issuer may not, outside of an open enrollment period, deny continued coverage or increase the copayment or coinsurance amount for a prescription drug to a medically stable enrollee if:

- the enrollee or the prescribing provider requests the continued coverage;
- the drug had previously been covered by the plan for the enrollee's medical condition in the current plan year;
- a participating provider continues to prescribe the drug for the enrollee's medical condition;
- the drug is a maintenance medication or for the treatment of a chronic condition;
- the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition; and
- the enrollee continues to be enrolled in the plan.

The issuer may continue to:

- require generic substitution during the plan year;
- add new drugs to its formulary during the plan year if the changed formulary applies only to new prescriptions;
- remove drugs from its formulary because of patient safety concerns, drug recall or removal from the market, or medical evidence indicating no therapeutic effect of the drug.

A participating prescriber may prescribe a different drug covered by the plan if it is medically appropriate for the enrollee.

Substitute Bill Compared to Original Bill:

The substitute bill:

- limits the bill's application to individual market plans that offer a prescription drug benefit;
- limits the types of cost-sharing that may not be increased to copayments or coinsurance;
- allows issuers to deny continuing coverage or increase copayment or coinsurance amounts during open enrollment periods;
- requires an enrollee to request continued coverage in order to trigger the continuing coverage and copayment/coinsurance requirements;

- requires drugs subject to the continuing coverage and copayment/coinsurance requirements to be maintenance or medications for the treatment of a chronic condition;
- treats new and existing enrollees the same;
- allows an issuer to add new drugs to its formulary as long as the new formulary applies only to new prescriptions;
- allows an issuer to remove a drug from the formulary for reasons of patient safety concerns, drug recall or removal from the market, or medical evidence indicating no therapeutic effect; and
- applies the provisions of the bill to plans issued or renewed on or after January 1, 2018.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) When consumers are deciding which plan to select, they often look at the drugs that are covered and the level of cost-sharing. This is the contract you enter into when you purchase coverage. Once someone goes through the effort to make informed decisions about coverage, there should be a guarantee that these aspects of the plan will not change, except during open enrollment periods. This is not the case—enrollees are locked into a one-sided contract. Enrollees are not able to renegotiate with the issuer during the plan year, so it is unfair to allow the issuer to do so.

This bill addresses a barrier to continuity of care for chronic illness. Issuers engage in non-medical switching, which is a form of cost control like prior authorization. This is problematic when done without the consent of patients and providers. This may have adverse health impacts such as increased emergency room visits, hospitalizations, or worse. Non-medical switching may also cause people to miss work and go out of business. Non-medical switching is a form of contract breaking. Patients like organ transplant recipients often have complex medication regimens. Changes in the formulary may make these treatments out of reach. This bill will enable patients to stay on existing treatments.

Patients with mental illness work closely with providers to find the right treatment. Medications, which are a lifeline to these patients, can be complex—lots of demographic factors affect the patient's response. Medications are not easily interchangeable. What works for one patient may not work for another.

The prior authorization process can be lengthy and confusing. Formularies are changing constantly and it can take days to contact issuers and get the proper forms. In the meantime,

patients are left off their medications. Providers, not issuers, should determine the proper treatment for patients.

(Opposed) Issuers make changes to their formularies for many reasons, including making new and more effective treatments available to consumers. These treatments come onto the market year-round, not just during open enrollment periods. Many consumers have benefitted from these treatments being available to enrollees in the middle of the plan year. Changes to the formulary are made only after an independent clinical review by a provider panel, including physicians and pharmacists. This bill is duplicative of federal law, which already allows changes to a formulary to be appealed. Issuers already provide 30 days' notice to enrollees to ensure they will have time to consult with their provider. This bill will give the pharmaceutical industry the incentive to raise prices without allowing issuers to change their costs structures or switch to another drug. This bill will have an adverse effect on premium rates. If this bill applies to state-purchased health plans, it would have a significant fiscal impact.

(Other) Prescription drugs can be expenses and prices vary. If the patient is held harmless, the costs are still out there, which can have an impact on premium rates. This may affect an issuer's ability to plan.

Persons Testifying: (In support) Representative Jinkins, prime sponsor; Lauren Simonds, National Alliance for the Mentally Ill; Sheila Stickel, National Patient Advocate Association; Joyce Willms; Mitchell Ehmann; and Patrick Connor, National Federation of Independent Business.

(Opposed) Mel Sorensen, America's Health Insurance Plans; Sydney Smith Zvara, Association of Washington Healthcare Plans; Len Sorrin, Premera Blue Cross; Amber Bronnum Moore, Group Health Cooperative; and Chris Bandoli, Regence.

(Other) Lonnie Johns-Brown, Office of the Insurance Commissioner.

Persons Signed In To Testify But Not Testifying: None.