Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

SSB 6147

Brief Description: Concerning prescription drug insurance continuity of care.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Rivers, Cleveland, Walsh, Kuderer, Nelson, Carlyle, Angel, Hasegawa and Keiser).

Brief Summary of Substitute Bill

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

Hearing Date: 2/21/18

Staff: Jim Morishima (786-7191).

Background:

A health plan offering coverage to individuals or small groups is required, under the federal Patient Protection and Affordable Care Act (ACA), to cover 10 categories of essential health benefits, one of which is prescription drugs. To comply with the ACA'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. A carrier may design its prescription drug benefit to include cost control measures. A carrier may also create incentives for the use of generic drugs. An issuer must file its formulary quarterly with the Office of the Insurance Commissioner.

A carrier may not exclude or remove a drug from its formulary if the medication is the sole prescription medication option available to treat a covered disease or condition, unless the drug becomes available over-the-counter, is proven to be medically inefficacious, or has a documented medical risk to patient health. If the carrier removes a drug from the formulary for reasons other

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than withdrawal from the market, over-the-counter availability, or black box warnings issued by the federal Food and Drug Administration, the carrier must continue to cover the drug for the time period necessary for an enrollee to use the carrier's substitution process to request a continuation of coverage from the drug, unless patient safety requires swifter replacement.

A carrier's substitution process may be used by a provider and enrollee to request a substitution of a drug that is not on the formulary. The process may not unreasonably restrict an enrollee's access to medications for conditions that are not responsive to treatment. Subject to the terms and conditions of the policy, a carrier must permit substitution if the enrollee does not tolerate the covered drug, an enrollee's provider determines that the covered drug is not therapeutically efficacious, or the provider determines that a dosage is required for efficacious treatment that differs from the formulary dosage. If the carrier denies the request, the enrollee must be allowed to request review of the denial by an independent review organization.

Summary of Bill:

For plans issued or renewed on or after January 1, 2019, 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 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 and 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; and
- substitute a generically equivalent drug or an interchangeable biologic.

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

Appropriation: None.

Fiscal Note: Available.

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