SENATE BILL REPORT
SB 5160

As of January 25, 2017

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

Brief Description: Concerning prescription drug insurance continuity of care.

Sponsors: Senators Rivers, Cleveland, Keiser, O'Ban and Carlyle.

Brief History:
Committee Activity: Health Care: 1/24/17.

Brief Summary of Bill

- Regulated health plans may not make certain changes to their prescription drug coverage outside of an open enrollment period.

SENATE COMMITTEE ON HEALTH CARE

Staff: Mich'l Needham (786-7442)

Background: Health insurance plans offering coverage to individuals or small groups are required, under federal law to cover ten categories of essential health benefits, one of which is prescription drugs. Under state insurance regulations, health plans that choose to offer a prescription drug benefit must offer a benefit that the Insurance Commissioner determines does not result in an unreasonable restriction on the treatment of patients. A plan must ensure that a prescription drug benefit covers Federal Drug Administration (FDA) approved prescribed drugs, medications or drug therapies that are the sole prescription drug available for a covered medical condition. The prescription drug benefit may include cost control measures, including requiring a preferred drug substitution in a given therapeutic class, if the restriction is for a less expensive, equally therapeutic alternative product available to treat the condition, and the benefit design may create incentive for the use of generic drugs.

Under state insurance regulations, a health plan is not required to use a formulary as part of its prescription drug benefit design. If a formulary is used, a health plan must meet certain requirements when a formulary change occurs. A plan must not exclude or remove a medication from its formulary if the medication is the sole prescription medication option available to treat a disease or condition for which the health benefit plan, policy, or

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agreement otherwise provides coverage, unless the medication or drug is removed because it becomes available over-the-counter, is proven to be medically inefficacious, or a documented medical risk to patient health. If a drug is removed from the formulary for a reason other than withdrawal of the drug from the market, availability of the drug over-the-counter, or the issue of a black box warning by the FDA, an issuer must continue to cover a drug that is removed from the issuer's formulary for the time period required for an enrollee who is taking the medication at the time of the formulary change to use an issuer's substitution process to request continuation of coverage for the removed medication, and receive a decision through that process, unless patient safety requires swifter replacement. Formularies and related preauthorization information must be posted on the health plan contracted pharmacy benefit manager web site and must be current. Unless the removal is done on an immediate or emergency basis or because a generic equivalent becomes available without prior notice, formulary changes must be posted 30 days before the effective date of the change. In the case of an emergency removal, the change must be posted as soon as practicable, without unreasonable delay.

Summary of Bill: Beginning January 1, 2019, regulated health plans that include prescription drug coverage may not, outside of an open enrollment period, deny continued coverage or increase the copayment or coinsurance amount for a prescription drug if :

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

Nothing prohibits the health plan from requiring generic substitution during the current plan year; from adding new drugs to its formulary during the current plan year, as long as the changed formulary applies only to new prescriptions and not existing prescriptions; or from removing a drug from the plan's formulary for reasons of patient safety concerns, drug recall, or removal from the market. Nothing prohibits a participating prescribing provider from prescribing a different drug that is covered by the plan and medically appropriate for the enrollee.

Appropriation: None.

Fiscal Note: Not requested.

Creates Committee/Commission/Task Force that includes Legislative members: No.

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

Staff Summary of Public Testimony: PRO: Consumers choose health plans that provide the list of drugs they need and they need stability through the plan year since they cannot change plans if the formulary changes mid-year. Individuals with difficult to treat conditions

find changes in their medications after open enrollment very problematic. Plans should ensure individuals have access through the year with the same protections that exist for Medicare Part D. As a patient with lupus, I have had my medication taken away three times and have not been allowed to stay on it during the appeals process. My specialists know what the best product is for me and it is not appropriate for other providers to override that decision. I shouldn't have to fight every year or so to maintain access to my medication. Transplant patients understand the need to maintain a range of therapy and medications and we shop for health plans that cover our needs but it is upsetting when they change unexpectedly after open enrollment. Individuals in the small group market and individual market have to purchase these plans on a take it or leave it approach, there is no negotiating over the policies and we need to rely on the contract to remain steady for the course of the plan year.

CON: Plans are concerned with increasing health care costs and any limitations on the ability to control costs. Plans adapt as quickly as possible as new drugs come on the market or as new research changes the medical advice for a drug. Formulary changes are done by an independent pharmacy and therapy committee that evaluates the drugs for the best medical decisions and opportunities to control costs. Plans also have processes to allow exceptions to access drugs after formulary changes occur. The cost control proposal is not well balanced since it does not impact the price of the drug the manufacturer is charging. If the manufacturer price could be held stable through the year, then it would be possible to hold the drug benefit stable and hold prices for consumers steady. Consumers get caught in the health care cost war with manufacturer price increases but this proposal just provides an incentive for pharma to increase prices with no insurance tools to manage the costs and consumers will ultimately lose with premium increases. Plans have incentives to ensure a prescription is efficacious and plans go through an elaborate process to review the drugs on the formulary. They also maintain an appeals process to make exceptions. Plans only make changes on a limited basis when significant cost increases have occurred or for safety reasons. If the standard is applied to the commercial market, it should be applied to all the markets including the self-insured state employee plan.

Persons Testifying: PRO: Senator Ann Rivers, Prime Sponsor; Brad Banks, HEP Education Project; Seth Dawson, National Alliance on Mental Illness, NAMI Washington; Mary McHale, American Cancer Society Cancer Action Network; Patrick Connor, NFIB/ Washington; Joyce Willms, citizen; David Hall, TRIO Pacific NW.

CON: Steve Gano, Premera; David Knutson, Association of Washington Healthcare Plans; Lonnie Johns-Brown, Office of the Insurance Commissioner; Mel Sorensen, America's Health Insurance Plans, Cigna; Zach Snyder, Regence BlueShield.

Persons Signed In To Testify But Not Testifying: No one.