SENATE BILL REPORT
ESHB 1879

As of April 1, 2019

Title: An act relating to regulating and reporting of utilization management in prescription drug benefits.

Brief Description: Regulating and reporting of utilization management in prescription drug benefits.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Jinkins, Cody, Harris, Macri, DeBolt, Pollet, Robinson, Tharinger and Doglio).

Brief History: Passed House: 3/08/19, 95-0.
Committee Activity: Health & Long Term Care: 3/22/19.

Brief Summary of Bill

- Requires clinical review criteria used to establish a prescription drug utilization management protocol to be evidence-based.
- Requires a health carrier or review organization that restricts coverage of a prescription drug through a prescription drug utilization management protocol to provide the patient and the prescribing practitioner with access to a clear, readily accessible, and convenient process to request an exception.
- Establishes requirements and timelines for utilization management exception requests.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Staff: Greg Attanasio (786-7410)

Background: Prescription drug utilization management means a set of techniques used by a health carrier or third-party administrator designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of prescription drugs. These techniques include, but are not limited to, prior authorization and step therapy. Prior authorization requires a provider or patient to get permission from a carrier before receiving

---

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.

coverage for a prescription drug, generally to ensure the drug is medically necessary or clinically appropriate. Step therapy, or a fail-first requirement, is a tool under which a carrier controls the order an enrollee takes certain drugs on the prescription drug formulary approved for a given condition. An enrollee must try one or more drugs chosen by their carrier before the carrier will cover the cost of a drug chosen by the prescribing provider.

Washington administrative rules allow a carrier to use utilization management tools requiring 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. When doing so, the carrier must establish a process the provider or insured may use to request a substitution for a covered drug. The process must not unreasonably restrict an insured's access to non-formulary or alternate medications when they are not responsive to the covered course of treatment.

Summary of Bill: For health plans issued or renewed on or after January 1, 2021, clinical review criteria used to establish a prescription drug utilization management protocol must be evidence-based and continually updated through review of new evidence, research, and newly developed treatments.

When a prescription drug is restricted through the use of a utilization management protocol, the patient and prescribing practitioner must have clear and convenient access on the health carrier's or utilization review organization's website to request an exception and, the exception approval criteria must be clearly posted. Carriers must disclose all rules related to the prescription drug utilization management process to all participating providers, including the information and documentation that must be completed for a request to be complete.

An exception must be granted if:

- the required prescription drug will likely cause physical or mental harm to the patient;
- the drug is expected to be ineffective based on known clinical characteristics of the patient and the drug;
- the patient tried the drug, or a substantially similar drug, under their current or previous health insurance and it was ineffective or caused an adverse event;
- the patient is stable on a drug selected by their health care provider; or
- the drug is not in the best interest of the patient, based on medical necessity, because the patient's use of the prescription drug is expected to (1) create a barrier to the patient's adherence to or compliance with the patient's plan of care, (2) negatively impact a comorbid condition of the patient, (3) cause a clinically predictable negative drug interaction, or (4) decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.

For non-urgent exception requests, carriers or review organizations must notify a provider within three business days if additional information is required to approve or deny the request. Once all required information is received, a health carrier or review organization must approve or deny a request within three business days, based on whether or not the information meets the exception criteria.

For urgent exception requests, carriers or review organizations must notify a provider within one business day if additional information is required to approve or deny the request. Once

all required information is received, a carrier or review organization must approve or deny a request within one business day if the information provided meets the exception criteria. A request is considered urgent when an enrollee is experiencing a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

Carriers must cover an emergency supply of the patient's medication if necessary while the exception request is processed. If the request is denied, the carrier must provide specific clinical review criteria relied upon for the denial. A carrier must provide 60 days notice for any new rules that apply to drug utilization management, and rules may not apply retroactively.

A carrier or review organization may require a patient to try an AB-rated generic equivalent or a biological product that is an interchangeable biological product prior to providing coverage for the equivalent branded drug.

Appropriation: None.

Fiscal Note: Available.

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: The bill is not meant to ban the use of utilization management, but standardize when an exception must be granted to make sure a patient's access to needed medications is not delayed. Step therapy can be a difficult process for people with chronic diseases. Waiting for appropriate medication can have negative impact on patient's health and impact their quality of life.

Persons Testifying: PRO: Representative Laurie Jinkins, Prime Sponsor; Erin Dziedzic, National Psoriasis Foundation; Heidi Barrett, citizen; Gordon MacDonald, citizen; Jeb Shepard, Washington State Medical Association.

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