FINAL BILL REPORT
SSB 5610

C 228 L 22
Synopsis as Enacted

Brief Description: Requiring cost sharing for prescription drugs to be counted against an enrollee's obligation, regardless of source.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Frockt, Cleveland, Conway, Dhingra, Hasegawa, Honeyford, Keiser, Kuderer, Liias, Lovelett, Lovick, Randall, Robinson, Saldaña, Salomon, Stanford, Van De Wege and Wilson, C.).

Senate Committee on Health & Long Term Care
House Committee on Health Care & Wellness

Background: Cost-sharing refers to the portion of costs for healthcare services an enrollee of a health plan is responsible for paying out-of-pocket before the plan covers the remainder of the cost. Cost-sharing can be in the form of a deductible, copayment, coinsurance, or similar obligations. The out-of-pocket maximum is the maximum amount an enrollee must pay for covered services in a plan-year across all types of cost-sharing obligations. Under the Affordable Care Act, most plans have an out-of-pocket maximum that varies depending on if the plan is for an individual or a family.

Cost-sharing obligations for prescription drug coverage varies among health plans, with some plans providing coverage before the deductible, some requiring the enrollee to meet a plan deductible before providing coverage, and some requiring the enrollee to meet a specific prescription drug deductible.

Summary: Beginning January 1, 2023, when calculating an enrollee's contribution to any applicable cost-sharing requirement, a health carrier offering a non-grandfathered health plan or health care benefit manager shall include any cost-sharing amounts paid by the enrollee directly or on behalf of the enrollee by another person for a covered prescription drug, if:

- the drug is without a generic equivalent or therapeutic equivalent preferred under the health plans formulary; or

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- there is a generic or therapeutic equivalent, but the enrollee obtained access to the drug through use of the exception request process.

The requirement is also applicable throughout an exception request process, including any appeal of a denial. This includes any time between the completion of the exception request process by a health care benefit manager and communication of the status of the request to the health carrier.

When calculating an enrollee's contribution to any applicable deductible, any amount paid on behalf of the enrollee by another person for a drug that is not subject to a deductible need not be included in the calculation, unless the terms of the enrollee's health plan require inclusion.

Any cost sharing amount paid directly of on behalf of the enrollee must be counted to applicable cost-sharing or out-of-pocket maximum requirements in full at the time rendered. The Insurance Commission may adopt any rules necessary to implement this requirement.

This requirement does not apply to a qualifying health plan for a health savings account to the extent necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under Internal Revenue Service laws, regulations, and guidance.

Votes on Final Passage:

Senate	46	3	
House	96	0	(House amended)
Senate	48	1	(Senate concurred)

Effective: June 9, 2022