SENATE BILL REPORT
SB 5794

As of January 26, 2022

Title: An act relating to continuity of coverage for prescription drugs prescribed for the treatment of behavioral health conditions.

Brief Description: Concerning continuity of coverage for prescription drugs prescribed for the treatment of behavioral health conditions.

Sponsors: Senators Dhingra, Kuderer, Frockt, Hasegawa, Lovelett, Randall, Van De Wege and Wilson, C..

Brief History:
Committee Activity: Health & Long Term Care: 1/28/22.

Brief Summary of Bill

- Prohibits health carriers from denying continued coverage or increasing cost-sharing requirements for drugs treating behavioral health conditions under certain circumstances.
- Prohibits Medicaid from requiring drug utilization management for drugs treating behavioral health conditions under certain circumstances.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Staff: Greg Attanasio (786-7410)

Background: Under the Affordable Care Act, small group and individual market health plans must cover certain 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

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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 drug is the sole drug option available to treat a disease or condition for which the health benefit plan, policy, or agreement otherwise provides coverage, unless the drug is removed because it becomes available over-the-counter, is proven to be medically inefficacious, or is a documented medical risk to patient health. If a drug is removed from the formulary for any other reason, a carrier must continue to cover the drug for the time period required for an enrollee to use the carrier's substitution process to request continuation of coverage for the drug, 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 and 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, 2023, 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 used for the assessment or treatment of a mental health condition to a medically stable enrollee if a participating provider continues to prescribe the drug, and the drug is considered safe and effective for treating the enrollee's medical condition, and if:

- the drug had previously been covered by the plan for the enrollee's medical condition during the current plan year; or
- the enrollee had been prescribed the drug from their prescribing provider for at least 90 days prior to enrollment in the plan.

A carrier is not prohibited from:

- requiring a generic substitution for the drug;
- adding a new drug to the formulary during the plan year as long as the change does not violate the continuity of coverage provision in this act; or
- removing a drug from the formulary for patient safety reasons.

A participating provider is not prohibited from prescribing an enrollee a different drug that is covered by the plan and medically appropriate for the enrollee.

Beginning January 1, 2023, the state Medicaid program may not require prescription drug utilization management protocols for prescription drugs necessary for the treatment of mental health conditions if the drug was dispensed to the enrollee during the previous 365 days and the enrollee is medically stable on the drug.

Appropriation: None.

Fiscal Note: Requested on January 25, 2022.

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

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