SENATE BILL REPORT
SB 5300

As Reported by Senate Committee On:
Health & Long Term Care, February 9, 2023

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, Billig, Cleveland, Frame, Hasegawa, Hunt, Keiser, Kuderer, Lovelett, Nguyen, Nobles, Randall, Rivers, Robinson, Shewmake, Valdez, Wellman and Wilson, C..

Brief History:
Committee Activity: Health & Long Term Care: 2/03/23, 2/09/23 [DPS].

Brief Summary of First Substitute Bill

- Prohibits health carriers from requiring substitution of a prescribed nonpreferred drug with a preferred drug or increasing an enrollee's cost sharing obligation when the prescription is for a refill of an antipsychotic, antidepressant, or antiepileptic drug, or any other drug prescribed to treat a serious mental illness.
- Prohibits all state purchased health care programs from requiring substitution of a nonpreferred drug with a preferred drug when the prescription is for a refill of an antipsychotic, antidepressant, or antiepileptic drug, or any other drug prescribed to treat a serious mental illness.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 5300 be substituted therefor, and the

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substitute bill do pass.

Signed by Senators Cleveland, Chair; Robinson, Vice Chair; Rivers, Ranking Member; Muzzall, Assistant Ranking Member; Conway, Dhingra, Holy, Padden, Randall and Van De Wege.

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 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 website, 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.

Health carriers must also establish a process that a provider and an enrollee may use to request substitution for a prescribed therapy, drug, or medication that is not on the formulary. This process may not unreasonably restrict an enrollee's access to non-formulary or alternative medicines for conditions not responsive to treatment. Carriers must also have a process for an enrollee to request an expedited review based on exigent circumstances such as experiencing a health condition that may jeopardize the enrollee's life, or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

Summary of Bill: The bill as referred to committee not considered.

Summary of Bill (First Substitute): Beginning January 1, 2025, health plans that include prescription drug coverage may not require the substitution of a nonpreferred drug with a preferred drug in a given therapeutic class, or increase an enrollee's cost-sharing obligation mid-plan year for the drug, if the prescription is for a refill of an antipsychotic, antidepressant, or antiepileptic drug, or any other drug prescribed to treat the enrollee's serious mental illness, the enrollee is medically stable on the drug, and a participating provider continues to prescribe the drug.

A carrier is not prohibited from:
- requiring a generic substitution for the drug;
- adding a new drug to the formulary during the plan year; or
- removing a drug from the formulary for patient safety reasons.

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

Beginning January 1, 2025, state purchased health care programs may not require substitution of a nonpreferred drug with a preferred drug when the prescription is for a t refill of an antipsychotic, antidepressant, antiepileptic drug, or any other drug prescribed to treat the enrollee's serious mental illness, and must fill the prescription as directed by the prescribing provider.

EFFECT OF CHANGES MADE BY HEALTH & LONG TERM CARE COMMITTEE (First Substitute):

- Removes the phrase "initial refill or subsequent refill" and replaces it with "refill"

Appropriation: None.

Fiscal Note: Available.

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

Effective Date: The bill takes effect on January 1, 2024.

Staff Summary of Public Testimony on Proposed Substitute: *The committee recommended a different version of the bill than what was heard.* PRO: Reliance on mental health drugs are drastically increased and it can take time to find out what works best for an individual. Once the right drug is found it must remain available and affordable. This bill will prevent drug changes that destabilize patients.

OTHER: Health plans share the concern of keeping patients stable, but would like the bill to

clarify that samples do not create an established therapy. The bill as written would require plans to maintain multiple formularies.

Persons Testifying: PRO: Senator Manka Dhingra, Prime Sponsor; Jane Beyer, Office of the Insurance Commissioner; Melanie Smith, NAMI Washington; Debbie Plotnick, Mental Heath America; Glen Chase; Robin Berger, Washington State Psychiatric Association (WSPA); Jaime Fazzone, Washington State Pharmacy Association Behavioral Health Special Interest Group.

OTHER: Jennifer Ziegler, Association of Washington Health Care Plans.

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