HOUSE BILL REPORT
SSB 6147

As Passed House - Amended:
February 27, 2018

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

Brief Description: Concerning prescription drug insurance continuity of care.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Rivers, Cleveland, Walsh, Kuderer, Nelson, Carlyle, Angel, Hasegawa and Keiser).

Brief History:
Committee Activity:
Health Care & Wellness: 2/21/18, 2/23/18 [DPA].
Floor Activity:
Passed House - Amended: 2/27/18, 98-0.

Brief Summary of Substitute Bill
(As Amended by House)

- Requires a health carrier to provide its enrollees with notice about its substitution process for prescription drugs.
- Requires a health carrier who grants a substitution request to continue to cover the drug throughout the plan year with no prior authorization.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 17 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Graves, Assistant Ranking Minority Member; Caldier, Clibborn, DeBolt, Harris, Jinkins, MacEwen, Maycumber, Riccelli, Robinson, Rodne, Slatter, Stonier and Tharinger.

Staff: Jim Morishima (786-7191).

Background:

A health plan offering coverage to individuals or small groups is required, under the federal Patient Protection and Affordable Care Act (ACA), to cover 10 categories of essential health

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benefits, one of which is prescription drugs. To comply with the ACA's prescription drug coverage requirement, an issuer must cover prescription drugs in a manner substantially equal to a benchmark plan selected by the state. The issuer's formulary is part of the prescription drug category and must be substantially equal to the formulary in the benchmark plan. A carrier may design its prescription drug benefit to include cost control measures. A carrier may also create incentives for the use of generic drugs. An issuer must file its formulary quarterly with the Office of the Insurance Commissioner.

A carrier may not exclude or remove a drug from its formulary if the medication is the sole prescription medication option available to treat a covered disease or condition, unless the drug becomes available over-the-counter, is proven to be medically inefficacious, or has a documented medical risk to patient health. If the carrier removes a drug from the formulary, it must provide prior notice to any enrollee who filled a prescription for the drug within the prior three months. If the drug was removed for reasons other than withdrawal from the market, over-the-counter availability, or black box warnings issued by the federal Food and Drug Administration, the carrier must continue to cover the drug for the time period necessary for an enrollee to use the carrier's substitution process to request a continuation of coverage from the drug, unless patient safety requires swifter replacement.

A carrier's substitution process may be used by a provider and enrollee to request a substitution of a drug that is not on the formulary. The process may not unreasonably restrict an enrollee's access to medications for conditions that are not responsive to treatment. Subject to the terms and conditions of the policy, a carrier must permit substitution if the enrollee does not tolerate the covered drug, an enrollee's provider determines that the covered drug is not therapeutically efficacious, or the provider determines that a dosage is required for efficacious treatment that differs from the formulary dosage. If the carrier denies the request, the enrollees in individual or small group plans must be allowed to request review of the denial by an independent review organization.

Summary of Amended Bill:

For health plans issued or renewed on or after January 1, 2019, an issuer must annually provide an enrollee with a separate, written notification of the substitution process that the enrollee or his or her provider may use to seek coverage of a prescription drug that is not on the formulary. The notice must include the following in plain language:

- a clear explanation of the substitution process, including timelines for standard and expedited review, documentation requirements, the availability of internal appeals, and the availability of review by an independent review organization, if applicable; and
- a statement that the issuer must continue to cover a drug that is removed from the formulary for the time period required for an enrollee who is taking the medication at the time of the removal to use the issuer's substitution process to request continuation of coverage and receive a decision through the process, unless patient safety requires swifter replacement.

The information must also be provided to an enrollee when the issuer provides notice to an enrollee that a drug is being removed from the formulary.

By December 31, 2018, the Insurance Commissioner must develop a model form that issuers may use to make the notifications.

For health plans issued or renewed on or after January 1, 2019, an issuer that grants a substitution request must provide coverage for the drug with no prior authorization for the remainder of the plan year, unless to do so violates state or federal laws relating to controlled substances.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on February 15, 2018.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) Finding the correct drug regimen for certain medical conditions can be a difficult, time-consuming process. Treatment for conditions like hepatitis C requires a drug regimen that cannot be interrupted. Treatment for certain conditions, like epilepsy, is individualized. The drugs used to treat these conditions are not interchangeable. If a patient is stable, he or she should be allowed to remain stable. Insurers often change their formularies in the middle of the plan year for non-medical reasons, which forces patients to switch their medications or pay higher out-of-pocket costs for their existing regimens. Switching patients to different medications is dangerous and can lead to side effects, lack of disease control, decreased medication adherence, increased hospitalizations and emergency room visits, loss of productivity and wages, and even death. This situation also affects employers, especially small employers. Medical professionals, not insurance companies, should determine appropriate treatment for patients. The substitution and appeals process is not working. Patients often do not even know they are being switched. Consumers do not know how to fight back against the insurance companies. Pharmacy benefit managers have contracts with pharmaceutical companies that protect them from price increases during the plan year. Pharmacists are the first line of defense. Patients often choose a plan because of the prescription coverage—they should be able to count on the coverage and not be non-medically switched. This bill says, "A deal is a deal." There is no evidence that this will increase premium costs since these protections have been enacted by the Medicare program and in other states. This bill should not be limited to the individual market.

(Opposed) This bill has a laudable purpose, but it has unintended consequences that are not fully understood. Insurers want to encourage the use of medically effective, cost-effective drugs. An insurer makes the decision to change a formulary carefully using its pharmacy and therapeutics committee. Changes to an insurer's formulary are good for consumers because they keep costs down and provide better value to consumers. This bill will freeze an insurers formulary and limit the insurer's ability to respond to price increases by the pharmaceutical company. If a pharmaceutical company knows that the formulary cannot be changed, it will not negotiate on price during the plan year, which will result in higher costs and increased premiums. Pharmaceutical companies are price-setters in the name brand market space because patents protect them from competition. It is therefore important to find other ways

to foster competition. Insurers should be able to offer the choice of a lower-cost equivalent drug. Insurers have to justify premium increases, while drug companies do not. Insurers currently have exception and substitution processes in place to address this issue, about which enrollees should be notified. Pharmaceutical companies will be the main beneficiaries of this bill.

Persons Testifying: (In support) Senator Rivers, prime sponsor; Joyce Willms, Yelm Senior Center; Carol McCarty; Debi Johnson, Washington State Urology Society; Conner Findley, Epilepsy Foundation; Heidi Barrett, Arthritis Foundation; Melissa Tribelhom, Northwest Parkinson's Foundation; Dedi Little, Washington State Pharmacy Association; James Paribello, Hepatitis Education Project; and Patrick Conner, National Federation of Independent Business.

(Opposed) Meg Jones, Association of Washington Healthcare Plans; Zach Snyder, Regence Blue Shield; Courtney Smith, Kaiser Permanente Washington; and Mel Sorenson, America's Health Insurance Plans.

Persons Signed In To Testify But Not Testifying: None.