SENATE BILL REPORT
SB 6147

As Reported by Senate Committee On:
Health & Long Term Care, January 23, 2018

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

Brief Description: Concerning prescription drug insurance continuity of care.

Sponsors: Senators Rivers, Cleveland, Walsh, Kuderer, Nelson, Carlyle, Angel, Hasegawa and Keiser.

Brief History:
Committee Activity: Health & Long Term Care: 1/16/18, 1/23/18 [DP, w/oRec].

Brief Summary of Bill

- Prohibits health plans from denying continued drug coverage or increasing the copayment/coinsurance amount outside of the open enrollment period.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: Do pass.
Signed by Senators Cleveland, Chair; Kuderer, Vice Chair; Rivers, Ranking Member; Bailey, Becker, Conway, Fain, Keiser and Van De Wege.

Minority Report: That it be referred without recommendation.
Signed by Senator Mullet.

Staff: LeighBeth Merrick (786-7445)

Background: A formulary is the list of drugs covered by a health plan. State law does not require health plans to use a formulary as part of its prescription drug benefit.

If a formulary is used, a health plan must not exclude or remove a medication from its formulary if the medication is the sole prescription medication option available to treat a disease or condition for which the health plan provides coverage, unless the medication or drug is removed because it becomes available over-the-counter, is proven to be medically inefficacious, or a documented medical risk to patient health.

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.

If a drug is removed from the formulary for a reason other than withdrawal of the drug from the market, availability of the drug over-the-counter, or the issue of a black box warning by the Food and Drug Administration, a health plan must continue to cover the drug the until the enrollee receives the health plan's decision for their continued coverage request, unless patient safety requires swifter replacement.

Formularies and related preauthorization information must be posted on the health plan contracted pharmacy benefit manager website and must be current. Formulary changes must be posted 30 days before the effective date of the change unless the removal is done on an immediate or emergency basis or because a generic equivalent becomes available without prior notice. 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, 2019, health plans that include prescription drug coverage must not deny continued coverage or increase the copayment or coinsurance amount for a prescription drug if:

- it is outside the open enrollment period;
- the drug had previously been covered by the plan for the enrollee's medical condition during the current plan year;
- a provider continues to prescribe the drug and it is a maintenance medication or treatment for a chronic condition;
- the drug is appropriately prescribed and considered safe and effective for treating the medical condition; and
- the enrollee continues to be enrolled in the health plan.

Health plans are permitted to require generic substitution during the current plan year; add new drugs to its formulary during the current plan year, as long as the changed formulary applies only to new prescriptions and not existing prescriptions; and remove a drug from its formulary for reasons of safety concerns, drug recall, or removal from the market. Prescribing providers are allowed to prescribe a different drug that is covered by the health plan and medically appropriate.

Appropriation: None.

Fiscal Note: Not requested.

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: Many people work for years trying to find a drug that works for them and to have the drug removed from coverage can be very destabilizing to their health and quality of life. The appeals process is extremely burdensome and a lot of people do not know how to navigate the process. Medications for chronic conditions can be very expensive and people choose their health plan based on the covered drugs that are listed at the time of open enrollment. A medication change should be a

decision made by a health care provider and the patient. This is not something that should be decided by a health plan for financial reasons.

CON: Formulary changes help keep patients safe and premiums low.

OTHER: Current regulations allow for patients to appeal a continued coverage denial.

Persons Testifying: PRO: Senator Ann Rivers, Prime Sponsor; Brad Forbes, NAMI Washington; Jeff Rochon, Washington State Pharmacy Association; Melissa Tribelhorn, Northwest Parkinson's Foundation; Jessica Veach, Epilepsy Foundation; Jessica Johnson, National Multiple Sclerosis Society; Shaina Smith, US Pain Foundation; Joyce Willms, citizen; Jason Sterne, Hepatitis Education Project; James Paribello, Hepatitis Education Project; Patrick Connor, NFIB Washington; David Hall, Transplant Recipients International Org.

CON: Courtney Smith, Kaiser Permanente Washington.

OTHER: Meg Jones, Association of Washington Healthcare Plans; Zach Snyder, Regence BlueShield.

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