SENATE BILL REPORT
SB 5806

As of February 8, 2019

Title: An act relating to regulating and reporting of utilization management in prescription drug benefits.

Brief Description: Regulating and reporting of utilization management in prescription drug benefits.

Sponsors: Senators Cleveland and Rivers.

Brief History:
Committee Activity: Health & Long Term Care: 2/11/19.

Brief Summary of Bill

- Creates requirements for the clinical review criteria used by health carriers to establish utilization management protocols.
- Requires an accessible process for patients and providers to request an exception from utilization management protocols.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Staff: Greg Attanasio (786-7410)

Background: Prescription drug utilization management means a set of techniques used by a health carrier or or third-party administrator designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of prescription drugs. These techniques include, but are not limited to, prior authorization and step therapy. Prior authorization requires a provider or patient to get permission from a carrier before receiving coverage for a prescription drug, generally to ensure the drug is medically necessary or clinically appropriate. Step therapy, or a fail-first requirement, is a tool under which a carrier controls the order an enrollee takes certain drugs on the prescription drug formulary approved for a given condition. An enrollee must try one or more drugs chosen by their carrier before the carrier will cover the cost of a drug chosen by the prescribing provider.

Washington administrative rules allow a carrier to use utilization management tools requiring preferred drug substitution in a given therapeutic class if the restriction is for a less

---

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.

expensive, equally therapeutic alternative product available to treat the condition. When doing so, the carrier must establish a process the provider or insured may use to request a substitution for a covered drug. The process must not unreasonably restrict an insured's access to non-formulary or alternate medications when they are not responsive to the covered course of treatment.

Summary of Bill: Clinical Practice Guidelines. A health carrier's or utilization review organization's clinical review criteria for a utilization management protocol must be based on clinical practice guidelines that are:

- developed and endorsed by a multidisciplinary panel of experts;
- based on high quality studies, research, and medical practice;
- continually updated through a review of new evidence and treatments; and
- created by a transparent process: (1) minimizing bias, (2) explaining the relationship between the treatment options and outcomes, (3) rating the quality of the evidence supporting recommendations, and (4) considering relevant patient subgroups and preferences.

Multidisciplinary Panel. The multidisciplinary panel must require members disclose any conflicts of interest with health care entities, insurers, health plans, and pharmaceutical manufacturers and recuse themselves when necessary. It must also use a methodologist to provide objectivity in the data analysis and provide an opportunity for public review and comments.

Alternative Process. In the absence of clinical practice guidelines, carriers may use peer-reviewed publications to establish clinical review criteria.

Exception to a Utilization Management Protocol. When a prescription drug is restricted through the use of a utilization management protocol, the patient and prescribing practitioner must have clear and convenient access on the health carrier's or utilization review organization's website to request an exception and, the exception approval criteria must be clearly posted. The health carrier or utilization organization must respond to the request or an appeal within 72 hours, or within 24 hours when exigent circumstances exist. If they do not respond within that time, the exception is deemed granted. An exception must be granted if:

- the required prescription drug will likely cause physical or mental harm to the patient;
- the drug is expected to be ineffective based on known clinical characteristics of the patient and the drug;
- the patient tried the drug, or a substantially similar drug, under their current or previous health insurance and it was ineffective or caused an adverse event;
- the drug is not in the best interest of the patient, based on medical necessity; and
- the patient is stable on a drug selected by their health care provider.

Carriers must cover an emergency supply of the patient's medication if necessary while the exception request is processed. If the request is denied, the carrier must provide specific reasons for the denial. A carrier must provide 90 days notice for any new rules that apply to drug utilization management and rules may not apply retroactively.

All provisions relating to clinical practice guidelines and exception process regulations apply only to health plans delivered, issued, or renewed on or after January 1, 2021.

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.