# HOUSE BILL REPORT
# SSB 5610

**As Passed House - Amended:**
March 2, 2022

**Title:** An act relating to requiring cost sharing for prescription drugs to be counted against an enrollee's out-of-pocket costs, deductible, cost sharing, out-of-pocket maximum, or similar enrollee obligation, regardless of the source of the payment.

**Brief Description:** Requiring cost sharing for prescription drugs to be counted against an enrollee's obligation, regardless of source.

**Sponsors:** Senate Committee on Health & Long Term Care (originally sponsored by Senators Frockt, Cleveland, Conway, Dhingra, Hasegawa, Honeyford, Keiser, Kuderer, Liias, Lovelett, Lovick, Randall, Robinson, Saldaña, Salomon, Stanford, Van De Wege and Wilson, C.).

**Brief History:**

**Committee Activity:**

Health Care & Wellness: 2/17/22, 2/23/22 [DP].

**Floor Activity:**

Passed House: 3/2/22, 96-0.

**Brief Summary of Substitute Bill**
**(As Amended by House)**

- Requires certain third-party payments to count towards an enrollee's cost-sharing obligation or out-of-pocket maximum for certain health plans.

## HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

**Majority Report:** Do pass. Signed by 11 members: Representatives Cody, Chair; Bateman, Vice Chair; Caldier, Assistant Ranking Minority Member; Bronoske, Davis, Macri, Maycumber, Riccelli, Simmons, Stonier and Tharinger.

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*This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.*

**Minority Report:** Without recommendation. Signed by 4 members: Representatives Schmick, Ranking Minority Member; Harris, Rude and Ybarra.

**Staff:** Jim Morishima (786-7191).

**Background:**

Health plans may impose cost-sharing as part of the prescription drug benefit of a health plan. This cost-sharing can vary depending on the health plan and the type of drug. Generally, enrollee cost-sharing for prescription drugs counts against the enrollee's out-of-pocket maximum, which is the enrollee's maximum financial responsibility for the plan year. However, federal law permits health carriers to restrict whether third-party payments count toward the out-of-pocket maximum.

**Summary of Amended Bill:**

For non-grandfathered health plans (including health plans offered to state and school employees) issued or renewed on or after January 1, 2023, a health carrier or a health care benefit manager must include cost-sharing amounts paid on behalf of the enrollee for certain prescription drugs when calculating the enrollee's contribution to any applicable cost-sharing or out-of-pocket maximum. The amounts must be applied toward the enrollee's applicable cost-sharing or out-of-pocket maximum in full at the time it is rendered.

This requirement is applicable to drugs that do not have a generic equivalent, drugs that do not have a therapeutic equivalent preferred under the health plans formulary, or drugs for which the enrollee obtained access via prior authorization, step therapy, or an exception process. The requirement is also applicable throughout an exception request process, including any appeal of a denial. This includes any time between the completion of the exception request process by a health care benefit manager and communication of the status of the request to the health carrier.

The requirement does not apply, however, to drugs not subject to a deductible.

The requirement does not apply to a qualifying health plan for a health savings account to the extent necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from a health savings account under Internal Revenue Service laws, regulations, and guidance.

The Insurance Commissioner may adopt any rules necessary to implement these requirements.

**Appropriation:** None.

**Fiscal Note:** Available.

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

**Staff Summary of Public Testimony:**

(In support) Many people have expensive health conditions, such as HIV or bleeding disorders, that require specialty medications with no generic equivalents. Many of these drugs are classified as specialty drugs, which means patients have to meet the deductible before the insurer pays anything. People often have to get prior authorization or participate in step therapy before they are put on these drugs. People have relied on coupons for many years to survive the financial burden. Insurers are telling patients they can no longer count the coupons toward their cost-sharing, which negates the financial benefit of the coupon and allows the insurers to suck up the benefit of the coupons for themselves. The financial impact of this practice is devastating on these patients, causing families to choose between medications and paying for other expenses like rent. This can cause a catch-22 for patients where they are unable to work, but are unable to afford their medications without working. This issue is an example of the gamesmanship people face in the current health care system. By not allowing coupons to count, the pharmacy benefit manager doubles its own benefit while reducing the amount they pay for the medications, which constitutes manipulation. Most solutions to this problem require federal action, but this bill will help for the time being. This bill maintains the status quo. This bill reflects the need for larger health care reform. Families will be unable to absorb the additional costs without this bill. Eleven other states have done this.

(Opposed) Drug copay coupons have become ubiquitous for brand name drugs. The coupons make the drugs cheaper for patients, but drastically increase costs for employers and insurers. The coupons inflate profits for pharmaceutical companies. According to a federal advisory bulletin, coupons steer patients toward more expensive drugs when there are cheaper alternatives like generics. Coupons do not consider patient need. Drugs with coupons increase in price faster than drugs that do not have coupons. This is inconsistent with the goal of decreasing the costs of care. It is unfair to use a coupon to get a drug for free and then demand the insurer to count what was received for free against the deductible. Coupons are considered illegal kickbacks under federal law and are prohibited for federal health care programs, which is a criminal offense. California has also banned coupons. This bill may be a good short-term solution, but will increase overall health care costs in the long-term. This bill does not strike the right balance.

**Persons Testifying:** (In support) Cindi Laws, Health Care for All Washington; Jonathan Frochtzwajg, Cascade AIDS Project; Stephanie Simpson, Bleeding Disorder Foundation of Washington; Kristen McNulty; Chantai Wood; Jim Freeburg, Patient Coalition of Washington; and Jenny Arnold, Washington State Pharmacy Association.

(Opposed) Bill Head, Pharmaceutical Care Management Association; Marissa Ingalls, Coordinated Care of Washington; Mel Sorensen, America's Health Insurance Plans and Cigna; Cindy Laubacher, CVS/Aetna; and Isaac Kastama.

**Persons Signed In To Testify But Not Testifying:** None.