Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1269

Brief Description: Amending the prescription drug affordability board.

Sponsors: Representatives Riccelli, Stonier and Macri; by request of Health Care Authority.

Brief Summary of Bill

- Removes the limits on the types of drugs that are eligible for review provided that benchmark criteria are met.
- Makes changes to threshold prices and percentage increases.
- Advances the date that the Prescription Drug Affordability Board is authorized to begin establishing upper payment limits by one year, to January 1, 2026, except for prescription drugs used solely for the treatment of a rare disease or condition.
- Eliminates references to a 90-day delay of rules or the adoption of upper payment limits.

Hearing Date: 2/1/23

Staff: Ingrid Lewis (786-7293).

Background:

The Prescription Drug Affordability Board (Board) is a five-member gubernatorial board within the Health Care Authority (HCA) established in 2022 that is directed to review prescription drug affordability data, perform affordability reviews, and establish prescription drug upper payment limits.

Beginning June 30, 2023, and yearly thereafter, the Board is required to identify drugs that have

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been on the market for at least seven years; are dispensed at a retail, specialty, or mail order pharmacy; are not designated by the United States Food and Drug Administration as a drug solely for the treatment of a rare disease or condition; and meet the following benchmarks:

- brand name prescription drugs introduced at a price of $60,000 or more per year, or course of treatment, or have a price increase of 15 percent or more in any 12-month period or 50 percent over a three-year period;
- biosimilar products with an initial price less than 15 percent below the reference brand price; and
- generic drugs costing $100 or more for a 30-day supply or less that have increased in price by 200 percent or more in the last 12 months.

The Board may choose to conduct up to 24 affordability reviews each year of drugs it identifies meeting the above thresholds. For any drug chosen for a review, the Board must establish an advisory group consisting of relevant stakeholders, including patients and patient advocates for the condition treated by the drug and a representative from the pharmaceutical industry. Affordability review must consider determinants of cost, availability of alternatives, and a variety of market characteristics.

Beginning January 1, 2027, and followed each year thereafter, the Board may set an upper payment limit for up to 12 prescription drugs. An upper payment limit for a prescription drug applies to all purchases of the drug by any entity and reimbursements for a claim for the drug by a health carrier when the drug is dispensed or administered to an individual in the state. Employer sponsored self-funded plans may elect to be subject to the upper payment limits.

The Board must establish an effective date for each upper payment limit which may not go into effect until at least 90 days after the next regular legislative session following the adoption of the limit, and at least six months after the adoption of the limit. The Board may reassess the upper payment limit for any drug annually, based on current economic factors.

Any individual denied coverage by a health carrier for a prescription drug because the drug was unavailable due to an upper payment limit established by the Board, may seek review of a denial through the carrier's grievance and appeal process, or through an independent review organization following the grievance and appeal process. If it is determined that the prescription drug should be covered based on medical necessity, the carrier may disregard the upper payment limit and must provide coverage for the drug.

If a manufacturer chooses to withdraw a drug from the market due to an upper payment limit for that drug, it must provide written notice to the state at least 180 days in advance. If a manufacturer withdraws a drug, it will be prohibited from selling the drug in the state for three years, unless it petitions HCA to reenter the market on the condition that it will make the drug available in compliance with the upper payment limit.

Any savings generated for a health plan that are attributable to the establishment of an upper

payment limit must be used to reduce costs to consumers, prioritizing the reduction of out-of-pocket costs for prescription drugs. By January 1, 2024, the Board must establish a formula for calculating savings for complying with this section.

Any rules adopted by the HCA and any upper payment limits adopted by the Board may not go into effect until at least 90 days after the next regular legislative session.

Summary of Bill:

All references to a 90-day delay of rules or the adoption of upper payment limits are eliminated.

The criteria limiting the types of prescription drugs that are eligible for review are removed; all prescription drugs are eligible for review provided that threshold criteria is met. The threshold for brand name prescription drug prices is lowered to $25,000 or more per year, or course of treatment, or price increases of 10 percent or more in any 12-month period or 25 percent over a three-year period.

The date that the Board is authorized to begin establishing upper payment limits is advanced by one year, to January 1, 2026, except for prescription drugs used solely for the treatment of a rare disease or condition, which the Board may begin establishing upper payment limits January 1, 2027.

If an individual is denied coverage by a health carrier for a prescription drug because the drug was unavailable due to an upper payment limit and it is determined that the prescription drug should be covered based on medical necessity, the carrier may disregard the upper payment limit and must provide coverage for the drug if all other covered therapeutic alternatives are ineffective or have intolerable side effects, or the drug is designated as a drug solely for the treatment of a rare disease or condition by the United States Food and Drug Administration.

The date that the Board must establish a formula to calculate savings is extended to July 1, 2025.

Appropriation: None.

Fiscal Note: Available.

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