HOUSE BILL REPORT
SHB 1979

As Passed House:
February 6, 2024

Title: An act relating to reducing the cost of inhalers and epinephrine autoinjectors.

Brief Description: Reducing the cost of inhalers and epinephrine autoinjectors.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Paul, Leavitt, Duerr, Reed, Ormsby, Callan, Kloba, Doglio, Fosse, Ortiz-Self, Hackney and Shavers).

Brief History:
Committee Activity:
Health Care & Wellness: 1/10/24, 1/24/24 [DPS].
Floor Activity:
Passed House: 2/6/24, 97-0.

Brief Summary of Substitute Bill

- Requires health plans, including health plans offered to public and school employees, to cap the total out-of-pocket cost for a 30-day supply of at least one inhaled corticosteroid and one inhaled corticosteroid combination product and at least one epinephrine autoinjector product containing at least two autoinjectors at $35.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 17 members: Representatives Riccelli, Chair; Bateman, Vice Chair; Schmick, Ranking Minority Member; Hutchins, Assistant Ranking Minority Member; Bronoske, Caldier, Davis, Graham, Harris, Macri, Maycumber, Mosbrucker, Orwall, Simmons, Stonier, Thai and Tharinger.

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.

Staff: Kim Weidenaar (786-7120).

Background:

Cost Sharing.
A health plan's cost sharing, the enrollee's share of the costs that they must pay out of pocket through a deductible, coinsurance, or copayment, is typically set by the health plan and often organized into tiers. State and federal law require some health services to be provided without cost sharing and state law currently caps the total amount that an enrollee is required to pay for a 30-day supply of insulin at $35.

Federal law requires high deductible health plans (HDHPs) that have an associated health savings account (HSA) to meet a number of requirements to allow enrollees to maintain tax-exempt contributions and withdrawals for their HSA, including generally prohibiting HDHPs from providing benefits until the minimum deductible for the plan year is satisfied. Federal law provides an exception to this prohibition for certain preventive care services, which the federal Internal Revenue Service (IRS) guidance has expanded to include specified prescription medications for certain conditions, such as insulin for the treatment of diabetes and inhaled corticosteroids for the treatment of asthma.

Asthma Inhalers and Epinephrine Autoinjectors.
Inhalers are small, handheld devices that allow you to breathe medicine in through your mouth, directly to your lungs. They are often used to treat asthma, but providers may prescribe them for other conditions. Bronchodilators and corticosteroids are common inhaled medications.

Epinephrine autoinjectors are devices that contain epinephrine, which is used to treat severe allergic reactions called anaphylaxis. Epinephrine autoinjectors are generally sold in a two pack, in case of user error, product failure, or if a second epinephrine autoinjector is necessary.

Summary of Substitute Bill:

Health plans, including health plans offered to public and school employees, issued or renewed on or after January 1, 2025, must cap the total amount that an enrollee is required to pay:

- for a 30-day supply of at least one covered inhaled corticosteroid and at least one covered inhaled corticosteroid combination at $35; and
- for at least one covered epinephrine autoinjector product containing at least two autoinjectors at $35.

Prescription asthma inhalers and epinephrine autoinjectors must be covered without being subject to a deductible, and any cost sharing paid by an enrollee must be applied toward the enrollee's deductible obligation, except as provided below for HDHPs with an HSA. A

health plan must ensure that an inhaled corticosteroid, inhaled corticosteroid product, and epinephrine autoinjector that meet the capped total amount requirements are always available to a patient.

For HDHPs offered as a qualifying health plan for an HSA, the health carrier must establish the plan's cost sharing for asthma inhalers that are not on the federal Internal Revenue Service's list of preventive care services and epinephrine autoinjectors at the minimum level necessary to preserve the enrollee's ability to claim tax-exempt contributions and withdrawals from the enrollee's HSA. If the IRS removes asthma inhalers from the list of preventive care services, the health carrier must establish the plan's cost sharing for the coverage of prescription asthma inhalers at the minimum level necessary to preserve the enrollee's ability to claim tax-exempt contributions from the enrollee's HSA. If the IRS adds epinephrine autoinjectors to the list of preventive care services, coverage must be provided without being subject to the deductible.

To the extent not prohibited by these requirements, health plans may apply drug utilization management strategies to inhaled corticosteroids, inhaled corticosteroid products, and epinephrine autoinjectors.

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) This bill helps build off the work done last session to reduce the cost of insulin and to make health care more affordable. Like insulin, we have seen costs for families skyrocket for asthma inhalers and epinephrine autoinjectors. These are life-saving medications.

Costs for asthma inhalers and epinephrine autoinjectors are higher because both these medications have a medicine that is developed and researched, as well as a device. Kids with asthma are generally prescribed multiple types of inhalers, and some inhalers do not have a generic and are very expensive at $200 per inhaler or more. There are significant negative health and economic impacts of not being able to afford an inhaler. Children whose families cannot afford an inhaler inevitably end up in the Emergency Room (ER), which costs everyone more and causes children to miss school and parents to miss work.

The cost of EpiPens has increased sixfold. Families may have to spend $2,000 a year just to make sure they have enough on hand to keep their kids out of the ER. Many families cannot afford this, and a reasonable cap on cost sharing of necessary medications is good

public policy. It is very scary to feel like you cannot breathe and like you are not going to live. Inhalers are vital and many people keep them within arm's length to make sure that they can live and not experience the sheer panic of not being able to breathe.

(Opposed) None.

(Other) Health plans recognize the life-saving nature of these medications, and most plans cover at or close to the level required in the bill currently. Based on an initial assessment, health plans do not see this bill having a huge impact on cost because this is often already the case. However, bills like these may drive individuals to use name-brand versions rather than generics, which drives up the cost for everyone. Accordingly, there is a request to include language regarding generics. This bill should also explore why drug prices are so high and perhaps there is a role for the Prescription Drug Affordability Board.

This bill applies to health plans offered to public and school employees. Most of these customers are using generic products that meet the cost thresholds in the bill. In fact, 99 percent of customers are using generic epinephrine autoinjectors, which are only a $10 copay for the Uniform Medical Plan. Language has been offered to the Chair and Sponsor to constrain the bill slightly to exclude name brands.

Persons Testifying: (In support) Representative Dave Paul, prime sponsor; Amy Garrett, Pediatric Associates of Whidbey Island; Jim Freeburg, Patient Coalition of Washington; and Bob Cooper.

(Other) Jennifer Ziegler, Association of Washington Health Care Plans; and Evan Klein, Health Care Authority.

Persons Signed In To Testify But Not Testifying: None.