**5610-S AMH CODY H2913.1 - NOT FOR FLOOR USE**

**SSB 5610** - H AMD **1223**

By Representative Cody

**ADOPTED 03/02/2022**

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec.**  A new section is added to chapter 48.43 RCW to read as follows:

(1)(a) Except as provided in (b) of this subsection, when calculating an enrollee's contribution to any applicable cost-sharing or out-of-pocket maximum, a health carrier offering a nongrandfathered health plan with a pharmacy benefit, or a health care benefit manager administering benefits for the health carrier, shall include any cost-sharing amounts paid by the enrollee directly or on behalf of the enrollee by another person for a covered prescription drug that is:

(i) Without a generic equivalent or a therapeutic equivalent preferred under the health plan's formulary;

(ii) With a generic equivalent or a therapeutic equivalent preferred under the health plan's formulary where the enrollee has obtained access to the drug through:

(A) Prior authorization;

(B) Step therapy; or

(C) The prescription drug exception request process under RCW 48.43.420; or

(iii) With a generic equivalent or therapeutic equivalent preferred under the health plan's formulary, throughout an exception request process under RCW 48.43.420, including any appeal of a denial of an exception request. If the health carrier utilizes a health care benefit manager to approve or deny exception requests, the exception request process for the purposes of this subsection (1)(a)(iii) also includes any time between the completion of the exception request process, including any appeal of a denial, and when the health care benefit manager communicates the status of the request to the health carrier.

(b) When calculating an enrollee's contribution to any applicable deductible, any amount paid on behalf of the enrollee by another person for a prescription drug that is not subject to payment of a deductible need not be included in the calculation, unless the terms of the enrollee's health plan require inclusion.

(2) Any cost-sharing amounts paid directly by or on behalf of the enrollee by another person for a covered prescription drug under subsection (1) of this section shall be applied towards the enrollee's applicable cost-sharing or out-of-pocket maximum in full at the time it is rendered.

(3) The commissioner may adopt any rules necessary to implement this section.

(4) This section applies to nongrandfathered health plans issued or renewed on or after January 1, 2023.

(5) This section 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 the enrollee's health savings account under internal revenue service laws, regulations, and guidance.

(6) For purposes of this section:

(a) "Health care benefit manager" has the same meaning as in RCW 48.200.020.

(b) "Person" has the same meaning as in RCW 48.01.070.

**Sec.**  RCW 41.05.017 and 2021 c 280 s 2 are each amended to read as follows:

Each health plan that provides medical insurance offered under this chapter, including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, are subject to the provisions of RCW 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545, 48.43.550, 70.02.110, 70.02.900, 48.43.190, 48.43.083, 48.43.0128, section 1 of this act, and chapter 48.49 RCW."

Correct the title.

EFFECT: Exempts drugs with a therapeutic equivalent preferred under the health plan's formulary from the requirement that a health carrier count all cost-sharing amounts regardless of source (except in circumstances involving prior authorization, step therapy, or an exception process). Requires a health carrier to count all cost-sharing amounts regardless of source throughout an exception request process, including any appeal of a denial of an exception request and including any time between the completion of an exception request process conducted by a health care benefits manager and when the health care benefits manager communicates the status of the request to the health carrier.