SENATE BILL REPORT
SSB 5610

As Amended by House, 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 & Long Term Care: 1/19/22, 1/26/22 [DPS, w/oRec].

Floor Activity: Passed Senate: 2/8/22, 46-3.
Passed House: 3/2/22, 96-0.

Brief Summary of First Substitute Bill

- Requires all cost-sharing amounts paid by or on behalf of an enrollee to count toward the enrollee's applicable cost-sharing requirement under certain circumstances.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 5610 be substituted therefor, and the substitute bill do pass.

Signed by Senators Cleveland, Chair; Frockt, Vice Chair; Conway, Keiser, Randall, Rivers, Robinson and Van De Wege.

Minority Report: That it be referred without recommendation.

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.

Signed by Senators Muzzall, Ranking Member; Padden and Sefzik.

Staff: Greg Attanasio (786-7410)

Background: Cost-sharing refers to the portion of costs for healthcare services an enrollee of a health plan is responsible for paying out-of-pocket before the plan covers the remainder of the cost. Cost-sharing can be in the form of a deductible, copayment, coinsurance, or similar obligations. The out-of-pocket maximum is the maximum amount an enrollee must pay for covered services in a plan- year across all types of cost-sharing obligations. Under the Affordable Care Act, most plans have an out-of-pocket maximum that varies depending on if the plan is for an individual or a family.

Cost-sharing obligations for prescription drug coverage varies among health plans, with some plans providing coverage before the deductible, some requiring the enrollee to meet a plan deductible before providing coverage, and some requiring the enrollee to meet a specific prescription drug deductible.

Summary of First Substitute Bill: Beginning January 1, 2023, when calculating an enrollee's contribution to any applicable cost-sharing requirement, a health carrier offering a non-grandfathered health plan or health care benefit manager 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:

- the drug is without a generic equivalent;
- there is a generic equivalent, but the enrollee obtained access to the drug through utilization or the exception request process.

A health carrier or health care benefit manager needs to count any cost-sharing amount toward the enrollee's deductible unless required by the plan.

Any cost sharing amount paid directly of on behalf of the enrollee must be counted to applicable cost-sharing or out-of-pocket maximum requirements in full at the time rendered. The Insurance Commission may adopt any rules necessary to implement this requirement.

This 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 the enrollee's health savings account under Internal Revenue Service laws, regulations, and guidance.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Original Bill: *The committee recommended a different version of the bill than what was heard.* PRO: Pharmacy benefit managers reduce the amount they have to pay by not accepting manufacturer coupons and requiring the patient to pay more. Patients rely on coupons for high cost drugs and without better price regulation these coupons are essential. There are no cheaper alternatives for many chronic conditions without generic drug alternatives.

CON: Manufacturers use coupons to drive patients to higher cost drugs. This practice is not allowed in Medicare. There could be unintended consequence of higher premiums by requiring the coupons are counted toward cost-sharing. Coupons do not actually reduce the cost of drugs, and manufacturers could simply lower the cost of the drug to better help patients. Coupons reduces the use of cheaper generic drugs and drugs with coupons have a higher price growth rate.

Persons Testifying: PRO: Senator David Frockt, Prime Sponsor; Jenny Arnold, Washington State Pharmacy Association; Stephanie Simpson, Bleeding Disorder Foundation of Washington; Kristin McNulty, Parent; Tammie Ladd, Patient; Chantai Wood, Pharmacy Technician; Jim Freeburg, Patient Coalition of Washington.

CON: William Head, Pharmaceutical Care Management Association; LuGina Mendez-Harper, Prime Therapeutics; Chris Bandoli, Association of WA Healthcare Plans; Jane Douthit, Regence BlueShield; Mel Sorensen, America's Health Insurance Plans.

Persons Signed In To Testify But Not Testifying: No one.

EFFECT OF HOUSE AMENDMENT(S):

- 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 costsharing 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.