SENATE BILL REPORT
SB 5794

As Reported by Senate Committee On:
Health & Long Term Care, February 2, 2022
Ways & Means, February 7, 2022

Title: An act relating to continuity of coverage for prescription drugs prescribed for the treatment of behavioral health conditions.

Brief Description: Concerning continuity of coverage for prescription drugs prescribed for the treatment of behavioral health conditions.

Sponsors: Senators Dhingra, Kuderer, Frockt, Hasegawa, Lovelett, Randall, Van De Wege and Wilson, C..

Brief History:
Committee Activity: Health & Long Term Care: 1/28/22, 2/02/22 [DP-WM, w/oRec]. Ways & Means: 2/05/22, 2/07/22 [DPS, w/oRec].

Brief Summary of First Substitute Bill

- Prohibits health carriers from requiring substitution of a prescribed nonpreferred drug with a preferred drug or increasing an enrollee's cost-sharing obligation when the prescription is for a refill of a drug to treat a mental health condition.
- Clarifies that all state purchased health care programs may not require substitution of a nonpreferred drug with a preferred drug when the prescription is for a refill of an antipsychotic or antidepressant drug and must fill the prescription as directed by the prescribing provider.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: Do pass and be referred to Committee on Ways & Means.
Signed by Senators Cleveland, Chair; Frockt, Vice Chair; Muzzall, Ranking Member;

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.

Conway, Keiser, Randall, Rivers, Robinson, Sefzik and Van De Wege.

Minority Report: That it be referred without recommendation.
Signed by Senators Holy and Padden.

Staff: Greg Attanasio (786-7410)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Substitute Senate Bill No. 5794 be substituted therefor, and the substitute bill do pass.

Signed by Senators Rolfes, Chair; Frockt, Vice Chair, Capital; Robinson, Vice Chair, Operating & Revenue; Wilson, L., Ranking Member; Brown, Assistant Ranking Member, Operating; Billig, Braun, Carlyle, Conway, Dhingra, Gildon, Hasegawa, Hunt, Keiser, Mullet, Muzzall, Pedersen, Rivers, Van De Wege, Wagoner, Warnick and Wellman.

Minority Report: That it be referred without recommendation.
Signed by Senators Schoesler, Assistant Ranking Member, Capital; Honeyford, Ranking Minority Member, Capital.

Staff: Sandy Stith (786-7710)

Background: Under the Affordable Care Act, small group and individual market health plans must cover certain categories of essential health benefits, one of which is prescription drugs. Under state insurance regulations, health plans that choose to offer a prescription drug benefit must offer a benefit that the insurance commissioner determines does not result in an unreasonable restriction on the treatment of patients. A plan must ensure that a prescription drug benefit covers Federal Drug Administration (FDA) approved prescribed drugs, medications, or drug therapies that are the sole prescription drug available for a covered medical condition. The prescription drug benefit may include cost control measures, including requiring a preferred drug substitution in a given therapeutic class, if the restriction is for a less expensive, equally therapeutic alternative product available to treat the condition, and the benefit design may create incentive for the use of generic drugs.

Under state insurance regulations, a health plan is not required to use a formulary as part of its prescription drug benefit design. If a formulary is used, a health plan must meet certain requirements when a formulary change occurs. A plan must not exclude or remove a medication from its formulary if the drug is the sole drug option available to treat a disease or condition for which the health benefit plan, policy, or agreement otherwise provides coverage, unless the drug is removed because it becomes available over-the-counter, is proven to be medically inefficacious, or is a documented medical risk to patient health. If a drug is removed from the formulary for any other reason, a carrier must continue to cover the drug for the time period required for an enrollee to use the carrier's substitution process to request continuation of coverage for the drug, and receive a decision through that

process, unless patient safety requires swifter replacement. Formularies and related preauthorization information must be posted on the health plan and contracted pharmacy benefit manager web site and must be current. Unless the removal is done on an immediate or emergency basis or because a generic equivalent becomes available without prior notice, formulary changes must be posted 30 days before the effective date of the change. In the case of an emergency removal, the change must be posted as soon as practicable, without unreasonable delay.

Summary of Bill: The bill as referred to committee not considered.

Summary of Bill (First Substitute): Beginning January 1, 2023, health plans that include prescription drug coverage may not require the substitution of a nonpreferred drug with a preferred drug in a given therapeutic class, or increase an enrollee's cost-sharing obligation mid-plan year for the drug, if the prescription is for a refill of a prescription drug used for the assessment and treatment of a mental health condition, the enrollee is medically stable on the drug, and a participating provider continues to prescribe the drug.

A carrier is not prohibited from:

- requiring a generic substitution for the drug;
- adding a new drug to the formulary during the plan year as long as the change does not violate the continuity of coverage provision in this act; or
- removing a drug from the formulary for patient safety reasons.

A participating provider is not prohibited from prescribing an enrollee a different drug that is covered by the plan and medically appropriate for the enrollee.

State purchased health care programs may not require substitution of a nonpreferred drug with a preferred drug when the prescription is for a refill of an antipsychotic or antidepressant drug and must fill the prescription as directed by the prescribing provider.

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 (Health & Long Term Care): PRO: Finding the right behavioral health treatment is more of an art than science and when there is a lack of continuity in coverage drug patients become destabilized. Prior authorization and administrative barriers lead to more emergency room visits and involvement in the criminal justice system. Requiring prior authorization is time consuming and destabilizing.

CON: Many issues this bill is trying to address have already been addressed, particularly regarding exceptions to utilization management. There needs to be flexibility for drug costs to control overall health care costs.

Persons Testifying (Health & Long Term Care): PRO: Senator Manka Dhingra, Prime Sponsor; Glen Chase, Comprehensive Healthcare; Laura Bay, Constituent, Mental Health America; Kathryn Lewandowsky, Whole Washington.

CON: Chris Bandoli, Association of WA Healthcare Plans; Mel Sorensen, America's Health Insurance Plans.

Persons Signed In To Testify But Not Testifying (Health & Long Term Care): No one.

Staff Summary of Public Testimony on First Substitute (Ways & Means): PRO: Finding the right behavioral health treatment is more of an art than science and when there is a lack of continuity in coverage drug patients become destabilized.

CON: We will look at the proposed sub and circle back with any potential impacts.

Persons Testifying (Ways & Means): PRO: Laura Bay, Constituent, Mental Health America.

CON: Chris Bandoli, Association of WA Healthcare Plans.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.