FINAL BILL REPORT
SSB 5300

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Synopsis as Enacted

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

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Dhingra, Billig, Cleveland, Frame, Hasegawa, Hunt, Keiser, Kuderer, Lovelett, Nguyen, Nobles, Randall, Rivers, Robinson, Shewmake, Valdez, Wellman and Wilson, C.).

Senate Committee on Health & Long Term Care
House Committee on Health Care & Wellness

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

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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 website, 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.

Health carriers must also establish a process that a provider and an enrollee may use to request substitution for a prescribed therapy, drug, or medication that is not on the formulary. This process may not unreasonably restrict an enrollee's access to non-formulary or alternative medicines for conditions not responsive to treatment. Carriers must also have a process for an enrollee to request an expedited review based on exigent circumstances such as experiencing a health condition that may jeopardize the enrollee's life, or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

Summary: Beginning January 1, 2025, for health plans that include prescription drug coverage, a health carrier or the health carrier's health care benefit manager 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 an antipsychotic, antidepressant, or antiepileptic drug, or any other drug prescribed to treat the enrollee's serious mental illness, 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; or
- removing a drug from the formulary for patient safety reasons.

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

Beginning January 1, 2025, 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, antidepressant, antiepileptic drug, or any other drug prescribed to treat the enrollee's serious mental illness, and must fill the prescription as directed by the prescribing provider.

Votes on Final Passage:

Senate	46	0	
House	98	0	(House amended)
Senate	48	0	(Senate concurred)

Effective: July 23, 2023
January 1, 2025 (Section 2)