WAC 284-43-5170 Prescription drug benefit disclosures. (1) A carrier must include the following information in the certificate of coverage issued for a health benefit plan, policy or agreement that includes a prescription drug benefit in addition to those required elsewhere in Titles 48 RCW and 284 WAC. The commissioner may disapprove any contract issued on or after January 1, 2018, if the requirements of this subsection are not met.

(a) A clear statement explaining that the health benefit plan uses the following in its coverage of drugs (as applicable):

(i) Exclusion of certain brand name or other medications from its formulary;

(ii) Therapeutic drug substitution;

(iii) Incentives for use of generic drugs (such as step-therapy protocols);

(iv) Prior authorization requirements;

(v) Mid-plan year formulary changes; or

(vi) Other limits of its prescription drug benefit.

(b) For health plans delivered, issued, or renewed on or before January 1, 2021, a clear explanation of the substitution process required under WAC 284-43-5080 that the enrollee or their provider must use to seek coverage of a prescription drug or medication that is not in the formulary or is not the carrier's preferred drug or medication for the covered medical condition.

(c) For health plans delivered, issued, or renewed on or after January 1, 2021, a clear explanation of the exception and substitution processes required under WAC 284-43-2021, 284-43-2022, and 284-43-5080.

(d) A clear statement explaining that consumers may be eligible to receive an emergency fill for prescription drugs under the circumstances described in WAC 284-170-470. The disclosure must include the process for consumers to obtain an emergency fill, and cost-sharing requirements, if any, for an emergency fill.

(e) The process for developing coverage standards and formularies, including the principal criteria by which drugs are selected for inclusion, exclusion, restriction or limitation.

(f) The process of changing formularies and coverage standards, including changes in the use of substitute drugs. If the plan has provisions for "grandfathering" certain ongoing prescriptions or other coverage exceptions, these practices must be disclosed.

(g) The disclosure must state whether drugs may move between tiers during a plan year and whether this may affect cost-sharing.

(h) Any medication management, disease management, or other pharmacy-related services reimbursed by the plan in addition to those required under state and federal law in connection with dispensing drugs, such as disease management services for migraine, diabetes, smoking cessation, asthma, or lipid management.

(i) The general categories of drugs excluded from coverage must be disclosed. Such categories may include items such as appetite suppressants, dental prescriptions, cosmetic agents or most over-the-counter medications. This subsection does not require that any particular category of coverage for drugs or pharmacy services should be excluded, reduced, or limited by a health plan.

(2) When a carrier eliminates a previously covered drug from its formulary, or establishes new limitations on coverage of the drug or medication, at a minimum a carrier must ensure that prior notice of the change will be provided as soon as is practicable, to enrollees who filled a prescription for the drug within the prior three months.

(a) Provided the enrollee agrees to receive electronic notice and such agreement has not been withdrawn, either electronic mail notice, or written notice by first class mail at the last known address of the enrollee, are acceptable methods of notice.

(b) If neither of these notice methods is available because the carrier lacks contact information for enrollees, a carrier may post notice on its website or at another location that may be appropriate, so long as the posting is done in a manner that is reasonably calculated to reach and be noticed by affected enrollees.

(3) A carrier and health plan may use provider and enrollee education to promote the use of therapeutically equivalent generic drugs. The materials must not mislead an enrollee about the difference between biosimilar or bioequivalent, and therapeutically equivalent, generic medications.

(4) A carrier must include the following statement in the certificate of coverage issued for a health benefit plan, policy, or agreement that includes a prescription drug benefit, and provide current contact information as prompted below:

YOUR PRESCRIPTION DRUG RIGHTS

You have the right to safe and effective pharmacy services. You also have the right to know what drugs are covered by your plan and the limits that apply. If you have a question or concern about your prescription drug benefits, please contact us (the health carrier) at (health carrier's contact phone number) or visit (health carrier's website). If you would like to know more about your rights, or if you have concerns about your plan, you may contact the Washington state office of insurance commissioner at 1-800-562-6900 or www.insurance.wa.gov. If you have a concern about the pharmacists or pharmacies serving you, please contact the Washington state department of health at 360-236-4700, www.doh.wa.gov, or HSQACSC@doh.wa.gov.

[Statutory Authority: RCW 48.02.060, 48.43.400, 48.43.410, and 48.43.420. WSR 20-24-105, § 284-43-5170, filed 12/1/20, effective 1/1/21. Statutory Authority: RCW 48.02.060, 48.43.510. WSR 17-01-166 (Matter No. R 2016-16), § 284-43-5170, filed 12/21/16, effective 1/21/17; WSR 16-19-086 (Matter No. R 2016-08), § 284-43-5170, filed 9/20/16, effective 10/21/16. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5170, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5170, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-825, filed 10/8/12, effective 11/8/12.]