

WSR 22-23-070
PERMANENT RULES
OFFICE OF THE
INSURANCE COMMISSIONER

[Insurance Commissioner Matter R 2022-05—Filed November 10, 2022, 10:04 a.m., effective December 11, 2022]

Effective Date of Rule: Thirty-one days after filing.

Purpose: Implementation of SSB 5610 (chapter 228, Laws of 2022) Prescription drug cost sharing—Enrollee contribution calculation. The rule making provides consistency and transparency to enrollees using third party payment assistance. The definitions of cost sharing and out-of-pocket maximum are clarified to include coupons. Additionally, carriers are required to provide enrollees disclosure of their benefits and appeal rights when third party payments are used.

Citation of Rules Affected by this Order: Amending WAC 284-43-5080.

Statutory Authority for Adoption: Section 1(3), chapter 228, Laws of 2022, SSB 5610.

Adopted under notice filed as WSR 22-17-135 on August 23, 2022.

A final cost-benefit analysis is available by contacting Simon Casson, P.O. Box 40260, Olympia, WA 98504, phone 360-725-7038, fax 360-586-3109, email Simon.Casson@OIC.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 1, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 10, 2022.

Mike Kreidler
Insurance Commissioner

OTS-3915.3

AMENDATORY SECTION (Amending WSR 20-24-105, filed 12/1/20, effective 1/1/21)

WAC 284-43-5080 Prescription drug benefit design. (1) A carrier may design its prescription drug benefit to include cost control measures, including requiring 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.

(2) A carrier may include elements in its prescription drug benefit design that, where clinically feasible, create incentives for the use of generic drugs. Examples of permitted incentives include, but

are not limited to, refusal to pay for higher cost drugs until it can be shown that a lower cost drug or medication is not effective (also known as step therapy protocols or fail-first policies), establishing a preferred brand and nonpreferred brand formulary, or otherwise limiting the benefit to the use of a generic drug in lieu of brand name drugs, subject to a substitution process as set forth in subsection (3) of this section.

(3) A carrier may include a preauthorization requirement for its prescription drug benefit and its substitution process, based on accepted peer reviewed clinical studies, Federal Drug Administration black box warnings, the fact that the drug is available over-the-counter, objective and relevant clinical information about the enrollee's condition, specific medical necessity criteria, patient safety, or other criteria that meet an accepted, medically applicable standard of care.

(4) A carrier may require an enrollee to try an AB-rated generic equivalent or a biological product that is an interchangeable biological product prior to providing coverage for the equivalent branded prescription drug.

(5) A nongrandfathered health plan issued or renewed on or after January 1, 2023, that provides coverage for prescription drugs must comply with RCW 48.43.435.

(a) For the purposes of this subsection, any cost sharing amount paid directly by or on behalf of the enrollee by another person for a covered prescription drug, at the time it is rendered, must be applied in full toward the enrollee's applicable cost-sharing as defined in WAC 284-43-0160 and out-of-pocket maximum as defined in RCW 48.43.005 consistent with RCW 48.43.435.

(b) If an enrollee requests an exception under RCW 48.43.420 or appeals a denial of an exception request, and the request or appeal is still pending, any amount paid by or on behalf of an enrollee for a covered prescription drug must be applied towards the enrollee's contribution to any applicable deductible, copayment, coinsurance, or out-of-pocket maximum until the review is resolved and the status of the request is communicated to the carrier.

(c) The health carrier must disclose to the enrollee information about when third-party payments, including payments made through application of a manufacturer drug coupon or other manufacturer discount, are applied towards the enrollee's annual cost-sharing obligations, including applicable deductibles, copayments, coinsurances, or out-of-pocket maximums. The disclosure shall be included in the certificate of coverage (also commonly referred to as the member booklet or member handbook). Carriers are not required to use verbatim language from either the statute or regulation; however, the information provided to the enrollee about the application of third-party payments must be sufficiently detailed to address the situations set forth in RCW 48.43.435 (1) (a) (i) through (iii).

[Statutory Authority: RCW 48.02.060, 48.43.400, 48.43.410, and 48.43.420. WSR 20-24-105, § 284-43-5080, filed 12/1/20, effective 1/1/21. Statutory Authority: RCW 48.02.060, 48.18.140, and 48.43.510. WSR 17-03-087 (Matter No. R 2016-22), § 284-43-5080, filed 1/12/17, effective 2/12/17. WSR 16-01-081, recodified as § 284-43-5080, 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), § 284-43-817, filed 10/8/12, effective 11/8/12.]