H-1383.1

HOUSE BILL 1876

State of Washington 62nd Legislature 2011 Regular Session

By Representatives Green and Kenney

Read first time 02/08/11. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to prohibiting insurers from creating specialty
2 tiers for prescription drugs; adding a new section to chapter 48.43
3 RCW; and creating a new section.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 NEW SECTION. **Sec. 1.** (1) The legislature finds that:
6 (a) As prescription drug prices continue to escalate, other states
7 have experienced the creation by insurers of a new cost-sharing
8 mechanism known as prescription drug specialty tiers;
9 (b) Many insurers use a three-tiered drug formulary structure that
10 provides fixed cost prescription drug benefits to insureds, based on
11 generic, brand name preferred, and brand name nonpreferred
12 designations;
13 (c) Specialty tiers include the costly prescription drugs to which
14 some insurers are instituting percentage cost prescription drug
15 benefits that are causing some insureds to pay more than three thousand
16 dollars for one month's supply of medication;
17 (d) Such drugs are typically new, infusible biologics or plasma-
18 derived therapies produced in lesser quantities than other drugs and

1 not available as less costly brand name or generic prescription drugs;
2 and

3 (e) The cost-sharing, deductible, and coinsurance obligations for
4 certain drugs have become cost prohibitive for insureds trying to
5 overcome serious disease such as cancer, hemophilia, multiple
6 sclerosis, myositis, neuropathy, primary immunodeficiency disease, and
7 rheumatoid arthritis.

8 (2) The legislature finds that insurers are also increasing
9 prescription drug copays to amounts beyond the reach of most insureds
10 and that if an insurer utilizes the three-tiered drug formulary, the
11 amounts charged for brand name nonpreferred and specialty drug copays
12 should not have the effect of unfairly denying access to prescription
13 drugs covered by the health benefit plan and should not cost more than
14 is necessary to provide a reasonable incentive for insureds to use
15 brand name preferred prescription drugs.

16 (3) The legislature further finds that paying hundreds or even
17 thousands of dollars each month for prescription drugs would be a
18 strain for any person, but for people with chronic illnesses and life-
19 threatening conditions, this unfortunate social policy has the
20 potential to destroy a family's financial solvency or end the ability
21 to take a necessary medication. Specialty tiers are contrary to the
22 original purpose of insurance, which was the spreading of costs.
23 Specialty tiers create a structure where those who are sickest pay
24 more, and those who are healthy pay less. Therefore, the creation of
25 specialty tiers is an unlawful discriminatory practice.

26 (4) It is the intent of the legislature that every insured have
27 access to reasonable prescription drug benefits and that the creation
28 of specialty tiers will prevent the achievement of that intent.

29 (5) The legislature further intends that the office of the
30 insurance commissioner consider the discriminatory practice of
31 specialty tiers and advise the political subdivisions of the state of
32 Washington to not obtain insurance coverage that offers such policies
33 that may restrict the use of life-saving therapies due to the
34 extraordinary disparity in cost-sharing, deductibles, and coinsurance.

35 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW
36 to read as follows:

1 (1)(a) An insurer may not create specialty tiers that require
2 payment of a percentage cost of prescription drugs.
3 (b) An insurer may not establish tiers of prescription drug copays
4 in which the maximum prescription drug copay exceeds by more than five
5 hundred percent the lowest prescription drug copay charged under the
6 health benefit plan.
7 (c) If an insurer's health benefit plan provides a limit for out-
8 of-pocket expenses for benefits other than prescription drugs, the
9 insurer shall include one of the following provisions in the plan that
10 would result in the lowest out-of-pocket prescription drug cost to the
11 insured:
12 (i) Out-of-pocket expenses for prescription drugs must be included
13 under the plan's total limit for out-of-pocket expenses for all
14 benefits provided under the plan; or
15 (ii) Out-of-pocket expenses for prescription drugs per contract
16 year may not exceed one thousand dollars per insured or two thousand
17 dollars per insured family, adjusted for inflation.
18 (2) For purposes of this section:
19 (a) "Health benefit plan" means any plan provided by a health
20 carrier, to the extent not preempted by federal law or exempted by
21 state law. "Health benefit plan" does not mean one or more, or any
22 combination, of the following:
23 (i) Coverage only for accident or disability income insurance, or
24 any combination thereof;
25 (ii) Credit-only insurance;
26 (iii) Coverage for specified disease or illness;
27 (iv) Limited scope dental or vision benefits;
28 (v) Coverage issued as a supplement to liability insurance;
29 (vi) Automobile medical payment insurance or homeowners medical
30 payment insurance;
31 (vii) Insurance under which benefits are payable with or without
32 regard to fault and which is statutorily required to be contained in
33 any liability policy or equivalent self-insurance coverage; or
34 (viii) Hospital indemnity or other fixed indemnity insurance; and
35 (b) "Insurer" has the same meaning as "health carrier" in RCW
36 48.43.087.
37 (3) This section applies to all health benefit plans delivered or
38 issued for delivery or renewed on or after January 1, 2012.

1 (4) Except as provided in subsection (5) of this section, the
2 office of the insurance commissioner shall enforce this section. The
3 commissioner may adopt rules to carry out the purposes of this section.
4 (5) The office of the insurance commissioner shall cease
5 enforcement of this section if it determines that the requirements of
6 this section will result in the assumption by the state of additional
7 costs pursuant to section 1311(d)(3)(B), as such section was amended by
8 section 10104(e) of Title X, of the federal patient protection and
9 affordable care act, P.L. 111-148, as amended.

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