S-1134.1

SENATE BILL 5697

State of Washington 65th Legislature 2017 Regular Session

By Senators Rivers, Cleveland, Conway, Keiser, and Bailey

1 AN ACT Relating to developing a standardized prescription drug
2 benefit package for individual and small group market offerings;
3 amending RCW 48.43.700 and 48.43.705; adding a new section to chapter
4 48.43 RCW; and creating a new section.

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

6 NEW SECTION. **Sec. 1.** The patient out-of-pocket cost task force
7 held several extended discussions on the costs patients with chronic
8 medical conditions face associated with prescription drugs, and the
9 task force explored several benefit design strategies that might
10 reduce the impact of the out-of-pocket costs. Several states have
11 enacted laws requiring various levels of standardization in health
12 benefit design, primarily focused on reducing the out-of-pocket
13 obligations for prescription drugs, and providing information that
14 allows consumers to compare plans and select a plan that best fits
15 their needs. It is the intent of the legislature to establish a
16 process for the development and maintenance of a standardized
17 prescription drug benefit that shall be available in the individual
18 and small group markets.

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

(1) The commissioner, in collaboration with the health benefit exchange, shall convene a committee to develop a recommendation on a standardized prescription benefit design. Applications to participate in the committee shall be submitted to the commissioner, and the commissioner shall ensure that participants on the committee include representatives from the following groups: Insurance carriers, providers, patient groups, labor, small employers, large employers, and drug manufacturers. The commissioner shall retain a neutral consultant or facilitator to assist with meetings of the committee.

(2) The committee shall be convened no later than October 1, 2017, and shall examine the options for designing a standardized prescription drug benefit package for use in the small group and individual markets. Standardized benefit design components must consider limiting or eliminating coinsurance as a cost-sharing method, fixing the copayment amounts for medications, limiting deductibles for medications, and defining any necessary parameters for the tiers of coverage. The committee shall submit recommendations to the commissioner and the exchange for a standardized design by October 1, 2018. The commissioner shall adopt the recommendations in rule, ensuring that each carrier offering coverage in the individual and small group markets offer at least one health plan that includes the standardized benefit design, beginning with coverage offered for January 1, 2020.

(3) The committee shall be retained for an annual review of the standardized benefit design and any recommendations for modifications. The commissioner shall update the rule as needed to reflect recommendations from the committee.

Sec. 3. RCW 48.43.700 and 2014 c 31 s 1 are each amended to read as follows:

(1) For plan or policy years beginning January 1, 2014, a carrier offering a health benefit plan that meets the definition of bronze level in section 1302 of P.L. 111-148 of 2010, as amended, in the individual market outside of the exchange must also offer plans that meet the definition of silver and gold level plans in section 1302 of P.L. 111-148 of 2010, as amended, in the individual market outside of the exchange.

(2) For plan or policy years beginning January 1, 2014, a carrier offering a health benefit plan that meets the definition of bronze level in section 1302 of P.L. 111-148 of 2010, as amended, in the

small group market outside of the exchange must also offer plans that meet the definition of silver and gold level plans in section 1302 of P.L. 111-148 of 2010, as amended, in the small group market outside of the exchange.

(3) A health benefit plan meeting the definition of a catastrophic plan in RCW 48.43.005(8)(c)(i) may only be sold through the exchange.

(4) By December 1, 2016, the exchange board, in consultation with the commissioner, must complete a review of the impact of this section on the health and viability of the markets inside and outside the exchange and submit the recommendations to the legislature on whether to maintain the market rules or let them expire.

(5) The commissioner shall evaluate plans offered at each actuarial value defined in section 1302 of P.L. 111-148 of 2010, as amended, and determine whether variation in prescription drug benefit cost-sharing, both inside and outside the exchange in both the individual and small group markets results in adverse selection. If so, the commissioner may adopt rules to assure substantial equivalence of prescription drug cost-sharing.

(6) For plan or policy years beginning January 1, 2020, a carrier offering a health benefit plan in the individual or small group markets must include at least one health plan, in each market, that includes the standardized prescription drug benefit design developed under section 2 of this act.

Sec. 4. RCW 48.43.705 and 2014 c 31 s 2 are each amended to read as follows:

(1) All nongrandfathered individual and small group health plans, other than catastrophic health plans, offered outside of the exchange must conform with the actuarial value tiers specified in section 1302 of P.L. 111-148 of 2010, as amended, as bronze, silver, gold, or platinum.

(2) For plan or policy years beginning January 1, 2020, a carrier offering a health benefit plan in the individual or small group market must include at least one health plan, in each market, that includes the standardized prescription drug benefit design developed under section 2 of this act.

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