OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

R 2022-05 Cost-sharing for prescription drugs

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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.xxx (Substitute Senate Bill No. 5610, chapter 228, Laws 2022).

(a) **For the purposes of this subsection** cost sharing or out-of-pocket amounts include payments from all sources as though it was paid by the enrollee directly and must be applied in full toward the enrollee's applicable cost-sharing as defined in WAC 284-43-0160 or out-of-pocket maximum as defined in RCW 48.43.005 consistent with RCW 48.43.xxx (Substitute Senate Bill No. 5610, chapter 228, Laws 2022).

(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) A qualifying health plan for a health savings account (HSA-qualifying plan) is not subject to the requirements under RCW 48.43.xxx (Substitute Senate Bill No. 5610, chapter 228, Laws 2022). An HSA-qualifying plan may apply a deductible to coverage of prescription drugs only at a minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under Federal Internal Revenue Service laws and regulations. The individual and family deductibles applied to prescription drugs under an HSA-qualifying plan must be the minimum deductibles set by the Federal Internal Revenue Service for a plan to be an HSA-qualifying plan under Federal Internal Revenue Service laws, regulations, and guidance.

(d) For nongrandfathered health plans with a prescription drug benefit, the health carrier must disclose to the enrollee the following information in the enrollee's certificate of coverage:

A statement that any amounts paid by the enrollee directly for a prescription drug, or paid on behalf of the enrollee by another person for a prescription drug, including payments made through application of a manufacturer drug coupon or other manufacturer discount, must be counted towards an enrollee's contribution to any applicable deductible, copayment, coinsurance, or out-of-pocket maximum, if any of the following apply:

(i) The prescription drug has no generic equivalent or a therapeutic equivalent that is preferred under the health plan's formulary;

(ii) The prescription drug has a generic equivalent or therapeutic equivalent that is preferred under the health plan's formulary, but the enrollee has otherwise obtained access to the prescription

drug through prior authorization, step therapy or fail-first protocols, or the carrier's prescription drug exception request process under RCW 48.43.420;

(iii) Coverage for the prescription drug has been requested under RCW 48.43.420 and the decision to approve or deny the exception request has not been made and communicated to the carrier; or

(iv) Coverage for the branded prescription drug is being reviewed through the adverse benefit determination process under WAC 284-43-3000 through 284-43-3190 and no final and binding determination has been made and communicated to the carrier.

[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.]