RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: November 10, 2022
TIME: 10:04 AM

WSR 22-23-070

Agency: Office of the Insurance Commissioner

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: Implementation of SSB 5610 (Chapter 228, Laws of 2022)—Prescription Drug Cost Sharing—Enrollee Contribution Calculation. SSB 5610 (Chapter 228, Laws of 2022). The rulemaking 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.

Insurance Commissioner Matter R 2022-05

Citation of rules affected by this order:

New:
Repealed:
Amended: WAC 284-43-5080
Suspended:

Statutory authority for adoption: Section 1 subsection 3 SSB 5610 Chapter 228, Laws of 2022

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

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

Describe any changes other than editing from proposed to adopted version: There are no changes from the proposed version

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

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Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	1	Repealed	____

The number of sections adopted at the request of a nongovernmental entity:

	New	____	Amended	____	Repealed	____

The number of sections adopted on the agency's own initiative:

	New	____	Amended	____	Repealed	____

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	____	Amended	____	Repealed	____

The number of sections adopted using:

Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	____	Amended	____	Repealed	____

Date Adopted: November 10, 2022	**Signature:** 
Name: Mike Kreidler	
Title: Insurance Commissioner	

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).