WAC 284-43-5110 Cost-sharing for prescription drugs. (1) A carrier and health plan unreasonably restrict the treatment of patients if an ancillary charge, in addition to the plan's normal copayment or coinsurance requirements, is imposed for a drug that is covered because of one of the circumstances set forth in either WAC 284-43-817 or 284-43-818. An ancillary charge means any payment required by a carrier that is in addition to or excess of cost-sharing explained in the policy or contract form as approved by the commissioner. Cost-sharing means amounts paid directly to a provider or pharmacy by an enrollee for services received under the health benefit plan, and includes copayment, coinsurance, or deductible amounts.

(2) When an enrollee requests a brand name drug from the formulary in lieu of a therapeutically equivalent generic drug or a drug from a higher tier within a tiered formulary, and there is not a documented clinical basis for the substitution, a carrier may require the enrollee to pay for the difference in price between the drug that the formulary would have required, and the covered drug, in addition to the copayment. This charge must reflect the actual cost difference.

(3) When a carrier approves a substitution drug, whether or not the drug is in the carrier's formulary, the enrollee's cost-sharing

for the substitution drug must be adjusted to reflect any discount agreements or other pricing adjustments for the drug that are available to a carrier. Any charge to the enrollee for a substitution drug must not increase the carrier's underwriting gain for the plan beyond the gain contribution calculated for the original formulary drug that is replaced by the substitution.

(4) If a carrier uses a tiered formulary in its prescription drug benefit design, and a substitute drug that is in the formulary is required based on one of the circumstances in either WAC 284-43-817 or 284-43-818, the enrollee's cost sharing may be based on the tier in which the carrier has placed the substitute drug.

(5) If a carrier requires cost-sharing for consumers receiving an emergency fill as defined in WAC 284-170-470, then issuers must disclose that information to consumers within their policy.

WAC 284-43-5170 Prescription drug benefit disclosures. (1) A carrier must include the following information in the certificate of coverage issued for a health benefit plan, policy or agreement that includes a prescription drug benefit:

(a) A clear statement explaining that the health benefit plan, policy or agreement may cover brand name drugs or medication under the circumstances set forth in WAC 284-43-817 or 284-43-818, including, if a formulary is part of the benefit design, brand name drugs or other medication not in the formulary.

(b) A clear explanation of the substitution process that the enrollee or their provider must use to seek coverage of a prescription drug or medication that is not in the formulary or is not the carrier's preferred drug or medication for the covered medical condition.

(c) A clear statement explaining that consumers may be eligible to receive an emergency fill for prescription drugs under the circumstances described in WAC 284-43-9997 (284-43-325). The disclosure must include the process for consumers to obtain an emergency fill, and cost-sharing requirements, if any, for an emergency fill.

(2) When a carrier eliminates a previously covered drug from its formulary, or establishes new limitations on coverage of the drug or medication, at a minimum a carrier must ensure that prior notice of the change will be provided as soon as is practicable, to enrollees who filled a prescription for the drug within the prior three months.

(a) Provided the enrollee agrees to receive electronic notice and such agreement has not been withdrawn, either electronic mail notice, or written notice by first class mail at the last known address of the enrollee, are acceptable methods of notice.

(b) If neither of these notice methods is available because the carrier lacks contact information for enrollees, a carrier may post notice on its web site or at another location that may be appropriate, so long as the posting is done in a manner that is reasonably calculated to reach and be noticed by affected enrollees.

(3) A carrier and health plan may use provider and enrollee education to promote the use of therapeutically equivalent generic drugs. The materials must not mislead an enrollee about the difference between biosimilar or bioequivalent, and therapeutically equivalent, generic medications.

WAC 284-170-470 Pharmacy claims—Rejections, notifications and disclosures. Issuers must provide to billing pharmacies sufficient information about transactions initiated by the pharmacy so that pharmacy claims can be processed in a timely manner.

(1) For purposes of this section "claim rejection" is an administrative step in the claim process where a claim is neither paid nor denied, but is held awaiting a defined action from the pharmacist, prescriber, or member.

(2) An issuer must notify the billing pharmacy of a claim rejection electronically and make available to the pharmacy, utilizing the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard transaction, all required data elements, as well as the following information, to the extent supported by the transaction:

(a) Rejection reasons such as prior authorization, quantity level limit, and exclusion;

(b) Other medications to consider that would not require a preauthorization (if applicable);

(c) Other medications to consider that would require a preauthorization (if applicable);

(d) Instructions for further processing of claim or for more specific contact information which may include a reference to a specific location on a web site;

(e) Contact phone number of a person or department to contact who can provide additional information.

(3) Every issuer must notify its participating pharmacies of its claim process in its contracts.

(4) Every issuer must be responsible for ensuring that any person acting on behalf of or at the direction of the issuer or acting pursuant to carrier standards or requirements complies with these transaction standards.

(5) In every provider agreement, the issuer must:

(a) Disclose if the provider or pharmacy has the right to make a prior authorization request; and

(b) Provide that if the issuer requires the authorization number to be transmitted on a pharmaceutical claim, the issuer will provide the authorization number to the billing pharmacy. The authorization number will be communicated to the billing pharmacy after approval of a prior authorization request and upon receipt of a claim for that authorized medication.

(6) The prior authorization determination must be transmitted to the requesting party and must include the following:

(a) Information about whether a request was approved.

(b) If the request was made by the pharmacy, notification will additionally be made to the prescriber.

(7) In every provider agreement, every issuer will state that an issuer will authorize an emergency fill by the dispensing pharmacist and approve the claim payment. An emergency fill is only applicable when:

(a) The dispensing pharmacy cannot reach the issuer's prior authorization department by phone as it is outside of that department's business hours; or

(b) An issuer is available to respond to phone calls from a dispensing pharmacy regarding a covered benefit, but the issuer cannot reach the prescriber for full consultation.

(8) The issuer's emergency fill policy must include the following:

(a) The inclusionary and exclusionary list of medications provided for emergency fill by issuers. This list must be posted online on the issuer's web site; this can be accomplished by linking to a common web site dedicated to administrative simplification and available to the public, such as OneHealthPort.

(b) The authorized amount of the emergency fill will be no more than the prescribed amount up to a seven day supply or the minimum packaging size available at the time the emergency fill is dispensed.

(c) ~~An emergency fill medication does not necessarily constitute a covered health service.~~ An emergency fill is a covered benefit. However, ~~D~~determination as to whether the subsequent fill~~this~~ is a covered health service under the patient benefit will be made as part of the prior authorization processing.

(9) Pharmacies and issuers are not required to comply with these contract provisions if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.