RULE-MAKING ORDER

CR-103P (May 2009)
(Implements RCW 34.05.360)

Agency: Office of the Insurance Commissioner

Permanent Rule Only

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:
The rules clarify that carriers are required to disclose their emergency fill policies to consumers, including any cost-sharing requirements, if any. The rules clarify that an emergency fill is a covered benefit. Finally, the rules clarify that only pharmacy provider agreements need to reflect changes made in previous rulemaking (R 2014-13).

Insurance Commissioner Matter No. R 2016-08

Citation of existing rules affected by this order:
Repealed:
Amended: WAC 284-43-5110, WAC 284-43-5170, WAC 284-170-470
Suspended:

Statutory authority for adoption: RCW 48.02.060, RCW 48.43.510

Other authority:

PERMANENT RULE (Including Expedited Rule Making)
Adopted under notice filed as WSR **16-16-090** on July 29, 2016.
Describe any changes other than editing from proposed to adopted version: None

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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Date adopted: September 20, 2016

NAME (TYPE OR PRINT)
Mike Kreidler

SIGNATURE
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TITLE
Insurance Commissioner

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: September 20, 2016
TIME: 3:15 PM

WSR 16-19-086

(COMPLETE REVERSE SIDE)

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Federal statute:	New	0	Amended	0	Repealed	0
Federal rules or standards:	New	0	Amended	0	Repealed	0
Recently enacted state statutes:	New	0	Amended	0	Repealed	0

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

New	0	Amended	0	Repealed	0

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

New	0	Amended	3	Repealed	0

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

New	0	Amended	3	Repealed	0

The number of sections adopted using:

Negotiated rule making:	New	0	Amended	0	Repealed	0
Pilot rule making:	New	0	Amended	0	Repealed	0
Other alternative rule making:	New	0	Amended	3	Repealed	0

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 enrollees receiving an emergency fill as defined in WAC 284-170-470, then issuers must disclose that information to enrollees within their policy forms.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 284-170-470. 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.

AMENDATORY SECTION (Amending WSR 16-07-144, filed 3/23/16, effective 4/23/16)

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 pharmacy 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 pharmacy 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~~)) is a covered ((~~health service.~~)) benefit. However, determination as to whether ((~~this~~)) the subsequent fill 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.