SENATE DOCKET, NO. 1172 FILED ON: 1/16/2015

SENATE . . . . . No. 541

The Commonwealth of Massachusetts

PRESENTED BY:

Anthony W. Petruccelli

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act concerning out-of-pocket expenses for prescription drug coverage.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
Anthony W. Petruccelli	*First Suffolk and Middlesex*	
Barbara A. L'Italien	*Second Essex and Middlesex*	
Jeffrey N. Roy	*10th Norfolk*	
Sal N. DiDomenico	*Middlesex and Suffolk*	*1/26/2016*

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SENATE . . . . . No. 541

By Mr. Petruccelli, a petition (accompanied by bill, Senate, No. 541) of Anthony W. Petruccelli, Barbara L'Italien and Jeffrey N. Roy for legislation relative to out-of-pocket expenses for prescription drug coverage. Financial Services.

The Commonwealth of Massachusetts

In the One Hundred and Eighty-Ninth General Court
(2015-2016)

An Act concerning out-of-pocket expenses for prescription drug coverage.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 175 of the General Laws is hereby amended by inserting after section 47DDthe following section:-

Section 47EE. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Commissioner" means the Commissioner of the Division of Insurance.

"Cost-sharing" means coinsurance, copayments, deductibles, or any other out-of-pocket expense.

"Deductible'' means the amount of covered expenses which must be accumulated annually before benefits become payable as additional covered expenses incurred.

"Tiered formulary" means a formulary that provides coverage for prescription drugs as part of a health plan for which cost sharing, deductibles or coinsurance obligations are determined by category or tier of prescription drugs, that includes at least two different tiers.

(b) No policy, contract, agreement, plan or certificate of insurance delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs may:

(1) Impose any cost-sharing that exceeds one hundred dollars per thirty-day supply for a covered prescription drug; or

(2) Place all drugs in a given class on the highest cost-sharing tier in a tiered formulary.

(c) The provisions of subsection (b) of this section shall apply pre-deductible.

(d) The provisions of subsection (b) of this section shall apply to a high deductible health plan after the minimum deductible amounts required for such plans, as set forth in the Internal Revenue Code, 26 U.S.C. 223(c)(2)(A)(1), are met.

(e) A health plan that provides coverage for prescription drugs shall allow enrollees to request an exception to the formulary. Under such an exception, a non-formulary drug could be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual, or both.

(f) In the event an enrollee is denied an exception as provided by subsection (e) of this section, such denial shall be considered an adverse determination and will be subject to the health plan internal review process set forth in M.G.L. Ch. 176O.

(g) Nothing in this section shall be construed to require a health plan to:

(1) Provide coverage for any additional drugs not otherwise required by law;

(2) Implement specific utilization management techniques, such as prior authorization or step therapy; or

(3) Cease utilization of tiered cost-sharing structures, including those strategies used to incent use of preventive services, disease management, and low-cost treatment options.

Section 2. Chapter 176A of the General Laws is hereby amended by inserting after section 8FF the following section:-

Section 8GG. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Commissioner" means the Commissioner of the Division of Insurance.

"Cost-sharing" means coinsurance, copayments, deductibles, or any other out-of-pocket expense.

"Deductible'' means the amount of covered expenses which must be accumulated annually before benefits become payable as additional covered expenses incurred.

"Tiered formulary" means a formulary that provides coverage for prescription drugs as part of a health plan for which cost sharing, deductibles or coinsurance obligations are determined by category or tier of prescription drugs, that includes at least two different tiers.

(b) No contract between a subscriber and the corporation under an individual or group hospital service plan delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs may:

(1) Impose any cost-sharing that exceeds one hundred dollars per thirty-day supply for a covered prescription drug; or

(2) Place all drugs in a given class on the highest cost-sharing tier in a tiered formulary.

(c) The provisions of subsection (b) of this section shall apply pre-deductible.

(d) The provisions of subsection (b) of this section shall apply to a high deductible health plan after the minimum deductible amounts required for such plans, as set forth in the Internal Revenue Code, 26 U.S.C. 223(c)(2)(A)(1), are met.

(e) A health plan that provides coverage for prescription drugs shall allow enrollees to request an exception to the formulary. Under such an exception, a non-formulary drug could be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual, or both.

(f) In the event an enrollee is denied an exception as provided by subsection (e) of this section, such denial shall be considered an adverse determination and will be subject to the health plan internal review process set forth in M.G.L. Ch. 176O.

(g) Nothing in this section shall be construed to require a health plan to:

(1) Provide coverage for any additional drugs not otherwise required by law;

(2) Implement specific utilization management techniques, such as prior authorization or step therapy; or

(3) Cease utilization of tiered cost-sharing structures, including those strategies used to incent use of preventive services, disease management, and low-cost treatment options.

Section 3. Chapter 176B of the General Laws is hereby amended by inserting after section 4FF the following section:-

Section 4GG. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Commissioner" means the Commissioner of the Division of Insurance.

"Cost-sharing" means coinsurance, copayments, deductibles, or any other out-of-pocket expense.

"Deductible'' means the amount of covered expenses which must be accumulated annually before benefits become payable as additional covered expenses incurred.

"Tiered formulary" means a formulary that provides coverage for prescription drugs as part of a health plan for which cost sharing, deductibles or coinsurance obligations are determined by category or tier of prescription drugs, that includes at least two different tiers.

(b) No subscription certificate under an individual or group medical service agreement delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs may:

(1) Impose any cost-sharing that exceeds one hundred dollars per thirty-day supply for a covered prescription drug; or

(2) Place all drugs in a given class on the highest cost-sharing tier in a tiered formulary.

(c) The provisions of subsection (b) of this section shall apply pre-deductible.

(d) The provisions of subsection (b) of this section shall apply to a high deductible health plan after the minimum deductible amounts required for such plans, as set forth in the Internal Revenue Code, 26 U.S.C. 223(c)(2)(A)(1), are met.

(e) A health plan that provides coverage for prescription drugs shall allow enrollees to request an exception to the formulary. Under such an exception, a non-formulary drug could be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual, or both.

(f) In the event an enrollee is denied an exception as provided by subsection (e) of this section, such denial shall be considered an adverse determination and will be subject to the health plan internal review process set forth in M.G.L. Ch. 176O.

(g) Nothing in this section shall be construed to require a health plan to:

(1) Provide coverage for any additional drugs not otherwise required by law;

(2) Implement specific utilization management techniques, such as prior authorization or step therapy; or

(3) Cease utilization of tiered cost-sharing structures, including those strategies used to incent use of preventive services, disease management, and low-cost treatment options.

Section 4. Chapter 176G of the General Laws is hereby amended by inserting after section 4X the following section:-

Section 4Y. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Commissioner" means the Commissioner of the Division of Insurance.

"Cost-sharing" means coinsurance, copayments, deductibles, or any other out-of-pocket expense.

"Deductible'' means the amount of covered expenses which must be accumulated annually before benefits become payable as additional covered expenses incurred.

"Tiered formulary" means a formulary that provides coverage for prescription drugs as part of a health plan for which cost sharing, deductibles or coinsurance obligations are determined by category or tier of prescription drugs, that includes at least two different tiers.

(b) No s individual or group health maintenance delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs may:

(1) Impose any cost-sharing that exceeds one hundred dollars per thirty-day supply for a covered prescription drug; or

(2) Place all drugs in a given class on the highest cost-sharing tier in a tiered formulary.

(c) The provisions of subsection (b) of this section shall apply pre-deductible.

(d) The provisions of subsection (b) of this section shall apply to a high deductible health plan after the minimum deductible amounts required for such plans, as set forth in the Internal Revenue Code, 26 U.S.C. 223(c)(2)(A)(1), are met.

(e) A health plan that provides coverage for prescription drugs shall allow enrollees to request an exception to the formulary. Under such an exception, a non-formulary drug could be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual, or both.

(f) In the event an enrollee is denied an exception as provided by subsection (e) of this section, such denial shall be considered an adverse determination and will be subject to the health plan internal review process set forth in M.G.L. Ch. 176O.

(g) Nothing in this section shall be construed to require a health plan to:

(1) Provide coverage for any additional drugs not otherwise required by law;

(2) Implement specific utilization management techniques, such as prior authorization or step therapy; or

(3) Cease utilization of tiered cost-sharing structures, including those strategies used to incent use of preventive services, disease management, and low-cost treatment options.

Section 5. Sections 1 through 4 of this Act shall not apply to catastrophic plans as defined by M.G.L. Ch. 176J.

Section 6. This act shall apply to all policies, contracts and certificates of health insurance subject to section 47EE of chapter 175, section 8GG of chapter 176A, section 4GG of chapter

176B and section 4Y of chapter 176G of the General Laws delivered, issued or renewed on or after January 1, 2016.