

**HOUSE . . . . . No. 3223**

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**The Commonwealth of Massachusetts**

PRESENTED BY:

***Christine P. Barber***

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*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 to promote transparency in prescription drug prices.**

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
<i>Christine P. Barber</i>	<i>34th Middlesex</i>	<i>1/20/2017</i>
<i>Jason M. Lewis</i>	<i>Fifth Middlesex</i>	<i>12/20/2017</i>
<i>Marjorie C. Decker</i>	<i>25th Middlesex</i>	<i>12/20/2017</i>
<i>Carmine L. Gentile</i>	<i>13th Middlesex</i>	<i>12/20/2017</i>
<i>Mike Connolly</i>	<i>26th Middlesex</i>	<i>12/20/2017</i>
<i>Kenneth I. Gordon</i>	<i>21st Middlesex</i>	<i>12/20/2017</i>
<i>Daniel Cullinane</i>	<i>12th Suffolk</i>	<i>12/20/2017</i>
<i>Carolyn C. Dykema</i>	<i>8th Middlesex</i>	<i>12/20/2017</i>
<i>Paul R. Heroux</i>	<i>2nd Bristol</i>	<i>12/20/2017</i>
<i>Michael S. Day</i>	<i>31st Middlesex</i>	<i>12/20/2017</i>
<i>Dylan Fernandes</i>	<i>Barnstable, Dukes and Nantucket</i>	<i>12/20/2017</i>
<i>Chris Walsh</i>	<i>6th Middlesex</i>	<i>12/20/2017</i>
<i>Patricia D. Jehlen</i>	<i>Second Middlesex</i>	<i>12/20/2017</i>
<i>Mary S. Keefe</i>	<i>15th Worcester</i>	<i>12/20/2017</i>

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By Ms. Barber of Somerville, a petition (accompanied by bill, House, No. 3223) of Christine P. Barber and others relative to further regulating prescription drug price increases. Public Health.

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**The Commonwealth of Massachusetts**

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**In the One Hundred and Ninetieth General Court  
(2017-2018)**  
\_\_\_\_\_

An Act to promote transparency in prescription drug prices.

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

1           SECTION 1. Chapter 6D of the General Laws is amended by adding the following new  
2 Sections:

3           Section X- PHARMACEUTICAL COST TRANSPARENCY

4           (a) As used in this section:

5           (1) “Manufacturer” means the person that holds the application for a drug approved under  
6 section 505 of the Federal Food, Drug, and Cosmetic Act or the license issued under section 351  
7 of the Public Health Service Act, or who is responsible for setting the price for the drug.

8           (2) “Prescription drug” means a drug as defined in 21 U.S.C. § 321.

9           (b)(1) The Health Policy Commission, in collaboration with the Center for Health  
10 Information and Analysis, shall identify annually up to 15 prescription drugs on which the state  
11 spends significant health care dollars and for which the wholesale acquisition cost has increased

12 by 50 percent or more over the past five years or by 15 percent or more over the past 12 months,  
13 or is a new drug whose price may have a significant impact on the cost benchmark.

14 The drugs identified shall represent different drug classes.

15 (2) The Commission shall provide to the Office of the Attorney General the list of  
16 prescription drugs developed pursuant to this subsection and the percentage of the wholesale  
17 acquisition cost increase for each drug and shall make the information available to the public on  
18 the Commission's website.

19 (c)(1) For each prescription drug identified pursuant to subsection (b) of this section, the  
20 Office of the Attorney General shall require the drug's manufacturer to provide a justification for  
21 the increase in the wholesale acquisition cost of the drug in a format that the Attorney General  
22 determines to be understandable and appropriate. The manufacturer shall submit to the Office of  
23 the Attorney General all relevant information and supporting documentation necessary to justify  
24 the manufacturer's wholesale acquisition cost increase, which may include:

25 (A) all factors that have contributed to the wholesale acquisition cost increase;

26 (B) the percentage of the total wholesale acquisition cost increase attributable to each  
27 factor; and

28 (C) an explanation of the role of each factor in contributing to the wholesale acquisition  
29 cost increase.

30 (2) Nothing in this section shall be construed to restrict the legal ability of a prescription  
31 drug manufacturer to change prices to the extent permitted under federal law.

32 (d) The Attorney General shall provide an Annual Prescription Drug Transparency  
33 Report to the Legislature, the Health Policy Commission, and the Center for Health Information  
34 and Analysis on or before December 1 of each year based on the information received from  
35 manufacturers pursuant to this section. The Attorney General shall also post the report on the  
36 Office of the Attorney General’s website.

37 (e) In carrying out this section, the Attorney General and the Health Policy Commission  
38 shall ensure the protection of confidential commercial information and trade secrets.

39 (f) The Attorney General may bring an action for injunctive relief, costs, and attorneys’  
40 fees, and to impose on a manufacturer that fails to provide the information required by  
41 subsection (c) of this section a civil penalty of no more than \$10,000.00 per violation. Each  
42 unlawful failure to provide information shall constitute a separate violation.

43 Section XX- REPORT ON PRICE INCREASES

44 (a) As used in this section:

45 (1) Average Manufacturer Price has the meaning given the term in section 1927(k)(1) of  
46 the Social Security Act (42 U.S.C. 1396r–8(k)(1)).

47 (2) “Manufacturer” means the person that holds the application for a drug approved under  
48 section 505 of the Federal Food, Drug, and Cosmetic Act or the license issued under section 351  
49 of the Public Health Service Act, or who is responsible for setting the price for the drug.

50 (b)(1) The manufacturer of a prescription drug shall submit a report to the Health Policy  
51 Commission for each price increase of a prescription drug that will result in an increase in the  
52 average manufacturer price of that drug that is equal to 10 percent or more over a 12-month

53 period or the introduction of a new drug whose price may threaten the cost benchmark.

54

55 (2) Each report described in paragraph (1) shall be submitted to the Health Policy  
56 Commission not later than 30 days prior to the planned effective date of such price increase.

57 (c) A report under subsection (b) shall, at a minimum, include:

58 (1) With respect to the prescription drug—

59 (A) the percentage by which the manufacturer will raise the average manufacturer price  
60 of the drug on the planned effective date of such price increase;

61 (B) a justification for, and description of, each manufacturer's price increase that  
62 occurred during the 12-month period described in subsection (b)(1);

63 (C) the identity of the initial developer of the drug;

64 (D) a description of the history of the manufacturer's price increases for the drug since the  
65 approval of the application for the drug under section 505 of the Federal Food, Drug, and  
66 Cosmetic Act or the issuance of the license for the drug under section 351, or since the  
67 manufacturer acquired such approved application or license;

68 (E) the current list price of the drug;

69 (F) the total expenditures of the manufacturer on—

70 (i) materials and manufacturing for such drug; and

71 (ii) acquiring patents and licensing for such drug;

72 (G) the percentage of total expenditures of the manufacturer on research and development  
73 for such drug that was derived from Federal funds;

74 (H) the total expenditures of the manufacturer on research and development for such drug  
75 that is used for—

76 (i) basic and preclinical research;

77 (ii) clinical research;

78 (iii) new drug development;

79 (iv) pursuing new or expanded indications for such drug through supplemental  
80 applications under section 505 of the Federal Food, Drug, and Cosmetic Act; and

81 (v) carrying out post market requirements related to such drug, including those under  
82 section 505(o)(3) of such Act;

83 (I) the total revenue and the net profit generated from the prescription drug for each  
84 calendar year since the approval of the application for the drug under section 505 of the Federal  
85 Food, Drug, and Cosmetic Act or the issuance of the license for the drug under section 351, or  
86 since the manufacturer acquired such approved application or license; and

87 (J) the total costs associated with marketing and advertising for the prescription drug;

88 (2) With respect to the manufacturer:

89 (A) the total revenue and the net profit of the manufacturer for the 12-month period  
90 described in subsection (b)(1);

91 (B) the amount the manufacturer has spent on dividends and stock repurchases and the  
92 specific metrics used by the manufacturer to determine executive compensation, including any  
93 stock-based performance metrics, for the 12-month period described in subsection (b)(1); and

94 (C) the amount the manufacturer has provided in funding to consumer and disease  
95 advocacy groups for the 12-month period described in subsection (b)(1);

96 (D) any additional information the manufacturer chooses to provide related to drug  
97 pricing decisions, such as total expenditures on—

98 (i) drug research and development; or

99 (ii) clinical trials on drugs that failed to receive approval by the Food and Drug  
100 Administration; and

101 (3) such other related information as the Health Policy Commission considers  
102 appropriate.

103 (d) The Attorney General may bring an action for injunctive relief, costs, and attorney's  
104 fees, and to impose on a manufacturer that fails to provide the information required by  
105 subsections (b) and (c) of this section a civil penalty of no more than \$10,000.00 per violation.  
106 Each unlawful failure to provide information shall constitute a separate violation.

107 (e)(1) Not later than 30 days after the submission of a report under subsection (b), the  
108 Health Policy Commission shall post the report on the public Website of the Commission.

109

110 (2) In carrying out this section the Health Policy Commission shall ensure the protection  
111 of confidential commercial information and trade secrets.

112 SECTION 2. Chapter 6D of the General Laws is amended by striking section 8 and  
113 replacing it with the following new sections:

114 Section 8.

115 (a) Not later than October 1 of every year, the commission shall hold public hearings  
116 based on the report submitted by the center for health information and analysis under section 16  
117 of chapter 12C comparing the growth in total health care expenditures to the health care cost  
118 growth benchmark for the previous calendar year. The hearings shall examine health care  
119 provider, provider organization, prescription drug manufacturer and private and public health  
120 care payer costs, prices and cost trends, with particular attention to factors that contribute to cost  
121 growth within the commonwealth's health care system.

122 (b) The attorney general may intervene in such hearings.

123 (c) Public notice of any hearing shall be provided at least 60 days in advance.

124 (d) The commission shall identify as witnesses for the public hearing a representative  
125 sample of providers, provider organizations, prescription drug manufacturers, payers and others,  
126 including: (i) at least 3 academic medical centers, including the 2 acute hospitals with the highest  
127 level of net patient service revenue; (ii) at least 3 disproportionate share hospitals, including the 2  
128 hospitals whose largest per cent of gross patient service revenue is attributable to Title XVIII and  
129 XIX of the federal Social Security Act or other governmental payers; (iii) community hospitals  
130 from at least 3 separate regions of the commonwealth; (iv) freestanding ambulatory surgical  
131 centers from at least 3 separate regions of the commonwealth; (v) community health centers from  
132 at least 3 separate regions of the commonwealth; (vi) the 5 private health care payers with the  
133 highest enrollments in the commonwealth; (vii) any managed care organization that provides

134 health benefits under Title XIX; (viii) the group insurance commission; (ix) at least 3  
135 municipalities that have adopted chapter 32B; (x) at least 4 provider organizations, at least 2 of  
136 which shall be certified as accountable care organizations, 1 of which has been certified as a  
137 model ACO, which shall be from diverse geographic regions of the commonwealth; (xi) the  
138 prescription drug manufacturers whose drugs were identified in the latest Attorney General's  
139 Annual Prescription Drug Transparency Report and (xii) any witness identified by the attorney  
140 general or the center.

141 (e) Witnesses shall provide testimony under oath and subject to examination and cross  
142 examination by the commission, the executive director of the center and the attorney general at  
143 the public hearing in a manner and form to be determined by the commission, including, but not  
144 limited to: (i) in the case of providers and provider organizations, testimony concerning payment  
145 systems, care delivery models, payer mix, cost structures, administrative and labor costs, capital  
146 and technology cost, adequacy of public payer reimbursement levels, reserve levels, utilization  
147 trends, relative price, quality improvement and care-coordination strategies, investments in  
148 health information technology, the relation of private payer reimbursement levels to public payer  
149 reimbursements for similar services, efforts to improve the efficiency of the delivery system,  
150 efforts to reduce the inappropriate or duplicative use of technology and the impact of price  
151 transparency on prices; (ii) in the case of prescription drug manufacturers, testimony concerning  
152 all factors that have contributed to significant cost increases for their drugs, the percentage of  
153 cost increase attributable to each factor and an explanation of the role of each factor in  
154 contributing to such cost increases and their efforts in moving to value based drug pricing, and  
155 (iii) in the case of private and public payers, testimony concerning factors underlying premium  
156 cost and rate increases, the relation of reserves to premium costs, efforts by the payer to reduce

157 the use of fee-for-service payment mechanisms, the payer's efforts to develop benefit design,  
158 network design and payment policies that enhance product affordability and encourage efficient  
159 use of health resources and technology including utilization of alternative payment  
160 methodologies, efforts by the payer to increase consumer access to health care information,  
161 efforts by the payer to promote the standardization of administrative practices, the impact of  
162 price transparency on prices and any other matters as determined by the commission. The  
163 commission shall solicit testimony from any payer which has been identified by the center's  
164 annual report under subsection (a) of section 16 of chapter 12C as (1) paying providers more  
165 than 10 per cent above or more than 10 per cent below the average relative price or (2) entering  
166 into alternative payment contracts that vary by more than 10 per cent. Any payer identified by  
167 the center's report shall explain the extent of price variation between the payer's participating  
168 providers and describe any efforts to reduce such price variation.

169 (f) In the event that the center's annual report under subsection (a) of section 16 of  
170 chapter 12C finds that the percentage change in total health care expenditures exceeded the  
171 health care cost benchmark in the previous calendar year, the commission may identify  
172 additional witnesses for the public hearing. Witnesses shall provide testimony subject to  
173 examination and cross examination by the commission, the executive director of the center and  
174 attorney general at the public hearing in a manner and form to be determined by the commission,  
175 including, but not limited to: (i) testimony concerning unanticipated events that may have  
176 impacted the total health care cost expenditures, including, but not limited to, a public health  
177 crisis such as an outbreak of a disease, a public safety event or a natural disaster; (ii) testimony  
178 concerning trends in patient acuity, complexity or utilization of services; (iii) testimony  
179 concerning trends in input cost structures, including, but not limited to, the introduction of new

180 pharmaceuticals, medical devices and other health technologies; (iv) testimony concerning the  
181 cost of providing certain specialty services, including, but not limited to, the provision of health  
182 care to children, cancer-related health care and medical education; (v) testimony related to  
183 unanticipated administrative costs for carriers, including, but not limited to, costs related to  
184 information technology, administrative simplification efforts, labor costs and transparency  
185 efforts; (vi) testimony related to costs due the implementation of state or federal legislation or  
186 government regulation; and (vii) any other factors that may have led to excessive health care cost  
187 growth.

188 (g) The commission shall compile an annual report concerning spending trends and  
189 underlying factors, along with any recommendations for strategies to increase the efficiency of  
190 the health care system. The report shall be based on the commission's analysis of information  
191 provided at the hearings by providers, provider organizations and insurers, registration data  
192 collected under section 11, data collected by the center for health information and analysis under  
193 sections 8, 9 and 10 of chapter 12C and any other information the commission considers  
194 necessary to fulfill its duties under this section, as further defined in regulations promulgated by  
195 the commission. The report shall be submitted to the chairs of the house and senate committees  
196 on ways and means and the chairs of the joint committee on health care financing and shall be  
197 published and available to the public not later than December 31 of each year. The report shall  
198 include any legislative language necessary to implement the recommendations.