SENATE DOCKET, NO. 767 FILED ON: 1/18/2017

SENATE . . . . . No. 1163

The Commonwealth of Massachusetts

PRESENTED BY:

Joseph A. Boncore

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 relative to transparency and access in healthcare.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Joseph A. Boncore	*First Suffolk and Middlesex*
Jennifer E. Benson	*37th Middlesex*

SENATE DOCKET, NO. 767 FILED ON: 1/18/2017

SENATE . . . . . No. 1163

By Mr. Boncore, a petition (accompanied by bill, Senate, No. 1163) of Joseph A. Boncore and Jennifer E. Benson for legislation relative to transparency and access in healthcare. Public Health.

The Commonwealth of Massachusetts

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

An Act relative to transparency and access in healthcare.

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. The General Laws are hereby amended by inserting after Chapter 111O the following Chapter:-

CHAPTER 111P.

TRANSPARENCY BY DRUG MANUFACTURERS

Section 1. Definitions.

In this chapter, unless the context requires otherwise, the following words shall have the following meanings:-

"Department," the department of public health.

"Manufacturer," any entity that is engaged in the production, preparation, propagation, compounding, conversion or processing of prescription drugs, either directly or indirectly, by

extraction from substances of natural origin, or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis, or any entity engaged in the packaging, repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that a “manufacturer" shall not include a wholesale drug distributor or a retail pharmacist registered under section 24 of chapter 112.

“Prescription Drug,” a drug as defined in 21 U.S.C. section 321(g)(1) and approved by the Federal Food and Drug Administration for the treatment of disease in humans.

“Therapeutic category,” the category that includes the prescription drug in the most recently published U.S. Pharmacopeia Medicare Model Guidelines.

Section 2. Manufacturer transparency

Each manufacturer of a prescription drug that is sold or marketed in the commonwealth, and that has experienced a wholesale acquisition cost increase of 15 per cent or more over a 12 month period, shall file with the department the following information:

(a) With respect to the prescription drug,

(1) the current wholesale acquisition cost;

(2) the amount of the most recent increase in the wholesale acquisition cost expressed as a percentage; and

(3) the five-year history of any increases in the wholesale acquisition cost expressed as a percentage and the month and year each such increase took effect.

(b) With respect to the manufacturer,

(1) total costs paid for research and development in the prescription drug's therapeutic category;

(2) estimated costs incurred relating to research and development of new products, processes or services, including the costs of research and development of new products or services that were acquired or obtained via a license;

(3) research and development costs as a percentage of revenue;

(4) estimated total annual revenues for prescription drugs sold in North America; and

(5) if the manufacturer sells or markets in the commonwealth four or more prescription drugs covered or purchased by MassHealth pursuant to chapter 118E, total rebates, discounts or other price concessions paid to the commonwealth for such drugs in the aggregate and without disclosure of any information that is likely to compromise its financial, competitive or proprietary nature.

Section 3. Filings; publication

(a) Manufacturers shall file the information required under section two on a form prescribed by the department no later than 90 days after the effective date of the most recent wholesale acquisition cost increase for the prescription drug. Any documentary materials or data whatsoever made or received by any member or employee of the department and consisting of, or to the extent that such materials or data consist of, trade secrets or confidential or proprietary information of the manufacturer that may be submitted under this chapter, whether or not so designated by the manufacturer, shall not be deemed a public record of the department and specifically shall not be subject to the provisions of section 10 of chapter 66. The provisions of

section 1927(b)(3)(D) of the Social Security Act shall apply to an employee or consultant of the department in the same manner that such provisions apply to the Secretary of the Department of Health and Human Services and the Secretary of the Department of Veteran's Affairs.

(b) The department shall publish on its website no later than June 30 of each year the information submitted by manufacturers under this chapter during the preceding year in a manner that does not compromise its financial, competitive or proprietary nature.

SECTION 2. The General Laws are hereby amended by inserting after Chapter 175L the following Chapter:-

CHAPTER 175M.

TRANSPARENCY BY PHARMACY BENEFIT MANAGERS

Section 1. Definitions.

In this chapter, unless the context requires otherwise, the following words shall have the following meanings:-

"Commissioner," the commissioner of insurance or his designee.

"Covered entity," a health insurer, health benefit plan, or health maintenance organization; a non-profit hospital or medical service corporation; a health program administered by the commonwealth; or an employer, labor union, or other group of persons organized in the commonwealth that provide health coverage to covered individuals who are employed or reside in the commonwealth, but not including any self-funded plan that is exempt from state regulation pursuant to federal law.

“Covered individual,” a member, participant, enrollee, contract holder, policy holder, or beneficiary of a covered entity who is provided health coverage by the covered entity.

“Pharmacy benefits management," the procurement of prescription drugs at a negotiated rate for dispensation within the commonwealth, or the administration or management of prescription drug benefits provided by a covered entity for the benefit of covered individuals.

"Pharmacy benefits manager," an entity that performs pharmacy benefits management, including a person or entity acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity.

Section 2. Pharmacy benefits manager transparency

(a) Each pharmacy benefits manager under contract with a covered entity shall report to the covered entity and to the commissioner no later than June 30 of each year the following information for the preceding calendar year relative to such contract:

(1) The percentage of prescriptions for which a generic drug was available and dispensed by pharmacy type (generic dispensing rate);

(2) The aggregate amount and the type of rebates, discounts or price concessions (excluding bona fide service fees, which include but are not limited to distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs)) that

the pharmacy benefits manager negotiated and that were attributable to patient utilization under the covered entity's plan;

(3) The aggregate amount of the rebates, discounts or price concessions (excluding bona fide service fees, which include but are not limited to distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs)) that the pharmacy benefit manager negotiated and that were passed through to the covered entity and the total number of prescriptions that were dispensed; and

(4) The aggregate amount of the difference between the amount the covered entity paid to the pharmacy benefits manager and the amount that the pharmacy benefits manager paid retail pharmacies and mail order pharmacies, and the total number of prescriptions that were dispensed.

(b) Information submitted under this chapter shall be confidential and shall not be disclosed to any person by the commissioner or the covered entity receiving the information. Such information shall not be deemed a public record of the commissioner and specifically shall not be subject to the provisions of section 10 of chapter 66.

Section 3. Publication

No later than June 30 of each year, the commissioner shall issue a report to be published on the commissioner's website aggregating the information received by all pharmacy benefit managers under this chapter for the preceding year, provided that this information shall not be disclosed in a form that discloses the identity of a specific pharmacy benefit manager, a covered

entity, prices charged for prescription drugs or any associate rebates, discounts or price concessions, or any information that identifies a drug product or drug manufacturer.

SECTION 3. Chapter 175 of the General Laws is hereby amended by inserting after section 110M the following section:-

Section 110N. (a) A health insurance plan that issues any policy, contract, agreement, plan or certificate of insurance, delivered or renewed within the commonwealth on or after January 1, 2019, shall:

(1) Post the formulary for the health plan on its web site in a manner that is accessible and searchable by enrollees, potential enrollees, and providers;

(2) Update the formulary posted pursuant to subsection (a)(1) no later than twenty-four hours after making a change to the formulary;

(3) Use a standard template developed by the commissioner pursuant to subsection (d) to display the formulary or formularies for each product offered by the plan; and

(4) Include on any published formulary for the plan, including but not limited to the formulary posted pursuant to subsection (a)(1), the following:

(i) Any utilization management edits –- including prior authorization, step therapy edits, quantity limits, or other requirements -- for each specific drug included in the formulary;

(ii) If the plan uses a tier-based formulary, the plan shall specify for each drug listed on the formulary the specific tier the drug occupies and list the specific co-payments for each tier in the evidence of coverage;

(iii) For prescription drugs covered under the plan's medical benefit and typically administered by a provider, plans must disclose to enrollees and potential enrollees all covered drugs and any cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan's formulary posted pursuant to subsection (a)(1) or via a toll free number that is staffed at least during normal business hours;

(iv) For each prescription drug included on the formulary under clause (ii) or (iii) that is subject to a coinsurance and dispensed at an in-network pharmacy the plan must:

(A) disclose the dollar amount of the enrollee's cost-sharing, or

(B) provide a dollar amount range of cost sharing for a potential enrollee of each specific drug included on the formulary, as follows:

(a) Under one hundred dollars: $;

(b) One hundred dollars to two hundred fifty dollars: $$;

(c) Two hundred fifty-one dollars to five hundred dollars: $$$; and

(d) Five hundred dollars to one thousand dollars: $$$$.

(e) Over one thousand dollars: $$$$$

(v) If the carrier allows the option for mail order pharmacy, the carrier separately must list the range of cost-sharing for a potential enrollee if the potential enrollee purchases the drug through a mail order facility utilizing the same ranges as provided in paragraph (4)(iv)(B).

(vi) A description of how medications will specifically be included in or excluded from the deductible, including a description of out-of-pocket costs that may not apply to the deductible for a medication.

(b) Each carrier offering or renewing a health insurance contract on or after January 1, 2019, must make available to current and potential enrollees the information mandated under this section. The information must be available prior to the beginning of the open enrollment period and must be done via a public website and through a toll free number that is posted on the carrier's website.

(c) Each carrier offering or renewing a health plan on or after January 1, 2019, must, no later than thirty days after the offer or renewal date, attest to the commissioner that the carrier has satisfied the requirements of this section.

(d) The commissioner may develop a standard formulary template for use by carriers for compliance with this section.

(e) For purposes of this section, "formulary" means the complete list of drugs preferred for use and eligible for coverage under the health plan.

SECTION 4. Chapter 176A of the General Laws is hereby amended by inserting after section 8KK the following section:-

Section 8LL. (a) A corporation under contract with a subscriber for an individual or group hospital service plan delivered or issued or renewed within the commonwealth on or after January 1, 2019, shall:

(1) Post the formulary for the health plan on the carrier's web site in a manner that is accessible and searchable by enrollees, potential enrollees, and providers;

(2) Update the formulary posted pursuant to subsection (a)(1) no later than twenty-four hours after making a change to the formulary;

(3) Use a standard template developed by the commissioner pursuant to subsection (d) to display the formulary or formularies for each product offered by the plan and

(4) Include on any published formulary for the plan, including but not limited to the formulary posted pursuant to subsection (a)(1), the following:

(i) Any utilization management edits –- including prior authorization, step therapy edits, quantity limits, or other requirements -- for each specific drug included in the formulary;

(ii) If the plan uses a tier-based formulary, the plan shall specify for each drug listed on the formulary the specific tier the drug occupies and list the specific co-payments for each tier in the evidence of coverage;

(iii) For prescription drugs covered under the plan's medical benefit and typically administered by a provider, plans must disclose to enrollees and potential enrollees, all covered drugs and any cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan's formulary posted pursuant to subsection (a)(1) or via a toll free number that is staffed at least during normal business hours;

(iv) For each prescription drug included on the formulary under clause (ii) or (iii) that is subject to a coinsurance and dispensed at an in-network pharmacy the plan must:

(A) disclose the dollar amount of the enrollee's cost-sharing, or

(B) provide a dollar amount range of cost sharing for a potential enrollee of each specific drug included on the formulary, as follows:

(a) Under one hundred dollars: $;

(b) One hundred dollars to two hundred fifty dollars: $$;

(c) Two hundred fifty-one dollars to five hundred dollars: $$$; and

(d) Five hundred dollars to one thousand dollars: $$$$.

(e) Over one thousand dollars: $$$$$

(v) If the carrier allows the option for mail order pharmacy, the carrier separately must list the range of cost-sharing for a potential enrollee if the potential enrollee purchases the drug through a mail order facility utilizing the same ranges as provided in paragraph (4)(iv)(B).

(vi) A description of how medications will specifically be included in or excluded from the deductible, including a description of out-of-pocket costs that may not apply to the deductible for a medication

(b) Each carrier offering or renewing a health plan on or after January 1, 2019, must make available to current and potential enrollees the information mandated under this section. The information must be available prior to the beginning of the open enrollment period and must be done via a public website and through a toll free number that is posted on the carrier's website.

(c) Each carrier offering or renewing a health plan on or after January 1, 2019, must, no later than thirty days after the offer or renewal date, attest to the commissioner that the carrier has satisfied the requirements of this section.

(d) The commissioner may develop a standard formulary template for use by carriers for compliance with this section.

(e) For purposes of this section, "formulary" means the complete list of drugs preferred for use and eligible for coverage under the health plan.

SECTION 5. Chapter 176B of the General Laws is hereby amended by inserting after section 4KK the following section:-

Section 4LL. (a) Any subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth on or after January 1, 2019, shall:

(1) Post the formulary for the health plan on the carrier’s web site in a manner that is accessible and searchable by enrollees, potential enrollees, and providers;

(2) Update the formulary posted pursuant to subsection (a)(1) no later than twenty-four hours after making a change to the formulary;

(3) Use a standard template developed by the commissioner pursuant to subsection (d)to display the formulary or formularies for each product offered by the plan and

(4) Include on any published formulary for the plan, including but not limited to the formulary posted pursuant to subsection(a)(1), the following:

(i) Any utilization management edits –- including prior authorization, step therapy edits, quantity limits, or other requirements -- for each specific drug included in the formulary;

(ii) If the plan uses a tier-based formulary, the plan shall specify for each drug listed on the formulary the specific tier the drug occupies and list the specific co-payments for each tier in the evidence of coverage;

(iii) For prescription drugs covered under the plan's medical benefit and typically administered by a provider, plans must disclose to enrollees and potential enrollees, all covered drugs and any cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan's formulary posted pursuant to subsection (a)(1) or via a toll free number that is staffed at least during normal business hours;

(iv) For each prescription drug included on the formulary under clause (ii) or (iii) that is subject to a coinsurance and dispensed at an in-network pharmacy the plan must:

(A) disclose the dollar amount of the enrollee's cost-sharing, or

(B) provide a dollar amount range of cost sharing for a potential enrollee of each specific drug included on the formulary, as follows:

(a) Under one hundred dollars: $;

(b) One hundred dollars to two hundred fifty dollars: $$;

(c) Two hundred fifty-one dollars to five hundred dollars: $$$; and

(d) Five hundred dollars to one thousand dollars: $$$$.

(e) Over one thousand dollars: $$$$$

(v) If the carrier allows the option for mail order pharmacy, the carrier separately must list the range of cost-sharing for a potential enrollee if the potential enrollee purchases the drug through a mail order facility utilizing the same ranges as provided in paragraph (4)(iv)(B).

(vi) A description of how medications will specifically be included in or excluded from the deductible, including a description of out-of-pocket costs that may not apply to the deductible for a medication

(b) Each carrier offering or renewing a health insurance contract on or after January 1, 2019, must make available to current and potential enrollees the information mandated under this section. The information must be available prior to the beginning of the open enrollment period and must be done via a public website and through a toll free number that is posted on the carrier's website.

(c) Each carrier offering or renewing a health plan on or after January 1, 2019, must, no later than thirty days after the offer or renewal date, attest to the commissioner that the carrier has satisfied the requirements of this section.

(d) The commissioner may develop a standard formulary template for use by carriers for compliance with this section.

(e) For purposes of this section, "formulary" means the complete list of drugs preferred for use and eligible for coverage under the health plan.

SECTION 6. Chapter 176G of the General Laws is hereby amended by inserting after section 4CC the following section:-

Section 4DD. (a) Any carrier issuing an individual or group health maintenance contract on or after January 1, 2019, shall:

(1) Post the formulary for the health plan on the carrier's web site in a manner that is accessible and searchable by enrollees, potential enrollees, and providers;

(2) Update the formulary posted pursuant to subsection (a)(1) no later than twenty-four hours after making a change to the formulary;

(3) Use a standard template developed by the commissioner pursuant to subsection (d) to display the formulary or formularies for each product offered by the plan and

(4) Include on any published formulary for the plan, including but not limited to the formulary posted pursuant to subsection (a)(1), the following:

(i) Any utilization management edits –- including prior authorization, step therapy edits, quantity limits, or other requirements -- for each specific drug included in the formulary;

(ii) If the plan uses a tier-based formulary, the plan shall specify for each drug listed on the formulary the specific tier the drug occupies and list the specific co-payments for each tier in the evidence of coverage;

(iii) For prescription drugs covered under the plans medical benefit and typically administered by a provider, plans must disclose to enrollees and potential enrollees, all covered drugs and any cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan's formulary posted pursuant to subsection (a)(1) or via a toll free number that is staffed at least during normal business hours;

(iv) For each prescription drug included on the formulary under clause (ii) or (iii) that is subject to a coinsurance and dispensed at an in-network pharmacy the plan must:

(A) disclose the dollar amount of the enrollee's cost-sharing, or

(B) provide a dollar amount range of cost sharing for a potential enrollee of each specific drug included on the formulary, as follows:

(a) Under one hundred dollars: $;

(b) One hundred dollars to two hundred fifty dollars: $$;

(c) Two hundred fifty-one dollars to five hundred dollars: $$$; and

(d) Five hundred dollars to one thousand dollars: $$$$.

(e) Over one thousand dollars: $$$$$

(v) If the carrier allows the option for mail order pharmacy, the carrier separately must list the range of cost-sharing for a potential enrollee if the potential enrollee purchases the drug through a mail order facility utilizing the same ranges as provided in paragraph (4)(iv)(B).

(vi) A description of how medications will specifically be included in or excluded from the deductible, including a description of out-of-pocket costs that may not apply to the deductible for a medication

(b) Each carrier offering or renewing a health insurance contract on or after January 1, 2019, must make available to current and potential enrollees the information mandated under this section. The information must be available prior to the beginning of the open enrollment period

and must be done via a public website and through a toll free number that is posted on the carrier’s website.

(c) Each carrier offering or renewing a health plan on or after January 1, 2019, must, no later than thirty days after the offer or renewal date, attest to the commissioner that the carrier has satisfied the requirements of this section.

(d) The commissioner may develop a standard formulary template for use by carriers for compliance with this section.

(e) For purposes of this section, "formulary" means the complete list of drugs preferred for use and eligible for coverage under the health plan.

SECTION 7. Chapter 32A of the General Laws is hereby amended by inserting after section 27 the following section:-

Section 28. (a) Any coverage offered by the commission to any active or retired employee of the commonwealth who is insured under the group insurance commission on or after January 1, 2019, shall:

(1) Post the formulary for the health plan on the carrier’s web site in a manner that is accessible and searchable by enrollees, potential enrollees, and providers;

(2) Update the formulary posted pursuant to subsection (a)(1) no later than twenty-four hours after making a change to the formulary;

(3) Use a standard template developed by the commissioner pursuant to subsection (d)to display the formulary or formularies for each product offered by the plan and

(4) Include on any published formulary for the plan, including but not limited to the formulary posted pursuant to subsection (a)(1), the following:

(i) Any utilization management edits –- including prior authorization, step therapy edits, quantity limits, or other requirements -- for each specific drug included in the formulary;

(ii) If the plan uses a tier-based formulary, the plan shall specify for each drug listed on the formulary the specific tier the drug occupies and list the specific co-payments for each tier in the evidence of coverage;

(iii) For prescription drugs covered under the plan's medical benefit and typically administered by a provider, plans must disclose to enrollees and potential enrollees, all covered drugs and any cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan's formulary posted pursuant to subsection (a)(1) or via a toll free number that is staffed at least during normal business hours;

(iv) For each prescription drug included on the formulary under clause (ii) or (iii) that is subject to a coinsurance and dispensed at an in-network pharmacy the plan must:

(A) disclose the dollar amount of the enrollee's cost-sharing, or

(B) provide a dollar amount range of cost sharing for a potential enrollee of each specific drug included on the formulary, as follows:

(a) Under one hundred dollars: $;

(b) One hundred dollars to two hundred fifty dollars: $$;

(c) Two hundred fifty-one dollars to five hundred dollars: $$$; and

(d) Five hundred dollars to one thousand dollars: $$$$.

(e) Over one thousand dollars: $$$$$

(v) If the carrier allows the option for mail order pharmacy, the carrier separately must list the range of cost-sharing for a potential enrollee if the potential enrollee purchases the drug through a mail order facility utilizing the same ranges as provided in paragraph (4)(iv)(B).

(vi) A description of how medications will specifically be included in or excluded from the deductible, including a description of out-of-pocket costs that may not apply to the deductible for a medication.

(b) Each carrier offering or renewing a health insurance contract on or after January 1, 2019, must make available to current and potential enrollees the information mandated under this section. The information must be available prior to the beginning of the open enrollment period and must be done via a public website and through a toll free number that is posted on the carrier’s website.

(c) Each carrier offering or renewing a health plan on or after January 1, 2019, must, no later than thirty days after the offer or renewal date, attest to the commissioner that the carrier has satisfied the requirements of this section.

(d) The commissioner may develop a standard formulary template for use by carriers for compliance with this section.

(e) For purposes of this section, "formulary" means the complete list of drugs preferred for use and eligible for coverage under the health plan.