

SENATE No. 542

The Commonwealth of Massachusetts

PRESENTED BY:

Eric P. Lesser

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 make out-of-pocket expenses for prescription drug coverage more affordable.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
<i>Eric P. Lesser</i>	<i>First Hampden and Hampshire</i>	
<i>Brian M. Ashe</i>	<i>2nd Hampden</i>	<i>1/31/2017</i>

SENATE No. 542

By Mr. Lesser, a petition (accompanied by bill, Senate, No. 542) of Eric P. Lesser and Brian M. Ashe for legislation to make out-of-pocket expenses for prescription drug coverage more affordable. Financial Services.

The Commonwealth of Massachusetts

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

An Act to make out-of-pocket expenses for prescription drug coverage more affordable.

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 175 of the General Laws is hereby amended by inserting after
2 section 47DD the following section:-

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

5 “Commissioner” means the Commissioner of the Division of Insurance.

6 “Cost-sharing” means coinsurance, copayments, deductibles, or any other out-of-pocket
7 expense.

8 “Deductible” means the amount of covered expenses which must be accumulated
9 annually before benefits become payable as additional covered expenses incurred.

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

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

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

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

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

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

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

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

- 31 (g) Nothing in this section shall be construed to require a health plan to:
- 32 (1) Provide coverage for any additional drugs not otherwise required by law;
- 33 (2) Implement specific utilization management techniques, such as prior authorization or
34 step therapy; or
- 35 (3) Cease utilization of tiered cost-sharing structures, including those strategies used to
36 incent use of preventive services, disease management, and low-cost treatment options.

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

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

41 “Commissioner” means the Commissioner of the Division of Insurance.

42 “Cost-sharing” means coinsurance, copayments, deductibles, or any other out-of-pocket
43 expense.

44 “Deductible” means the amount of covered expenses which must be accumulated
45 annually before benefits become payable as additional covered expenses incurred.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

77 “Commissioner” means the Commissioner of the Division of Insurance.

78 “Cost-sharing” means coinsurance, copayments, deductibles, or any other out-of-pocket
79 expense.

80 “Deductible” means the amount of covered expenses which must be accumulated
81 annually before benefits become payable as additional covered expenses incurred.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

113 “Commissioner” means the Commissioner of the Division of Insurance.

114 “Cost-sharing” means coinsurance, copayments, deductibles, or any other out-of-pocket
115 expense.

116 “Deductible” means the amount of covered expenses which must be accumulated
117 annually before benefits become payable as additional covered expenses incurred.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

148 chapter 176B and section 4Y of chapter 176G of the General Laws delivered, issued or renewed
149 on or after January 1, 2018.