HOUSE . . . . . No. 4518

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, March 4, 2020.

The committee on Financial Services, to whom was referred the petition (accompanied by bill, House, No. 3556) of Sean Garballey, John J. Lawn, Jr., and others relative to coverage for disease modifying prescription drugs for treatment of multiple sclerosis, reports recommending that the accompanying bill (House, No. 4518) ought to pass.

For the committee,

JAMES M. MURPHY.

FILED ON: 2/4/2020

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The Commonwealth of Massachusetts

In the One Hundred and Ninety-First General Court
(2019-2020)

An Act promoting continuity of care for multiple sclerosis treatment.

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 32A of the General Laws is hereby amended by adding the following section:-

Section 28. (a) The commission shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage for a drug for the modification of multiple sclerosis that the individual has already been prescribed and has already been taking. This section shall also require coverage for such an ongoing drug treatment for the modification of multiple sclerosis under any non-group policy.

Prior to receipt of the documentation described above, the commission shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage for a one-time 30-day transition fill, within the first 90 days of coverage under the plan, of a drug reimbursed through the commission's pharmacy benefit, or if a member's scheduled infusion occurs within the first 90 days of coverage under the plan, a one-time infusion of an FDA- approved drug reimbursed through the commission's medical benefit,

for the modification of multiple sclerosis that the member has already been prescribed and on which the member is stable.

(b) Notwithstanding the requirements of paragraph (a), the transition period shall not apply to the following: (i) new drugs for the modification of multiple sclerosis that have not been approved by the commission's or its contracted health plan's Pharmacy and Therapeutics (P & T) committee; (ii) products provided by sample; or (iii) products prescribed in a manner inconsistent with the FDA indication for the drug.

SECTION 2. Chapter 175 of the General Laws is hereby amended by inserting, after section 47II, the following section:-

Section 47JJ. (a) Any policy of accident and sickness insurance as described in section 108 that provides hospital expense and surgical expense insurance and that is delivered, issued or subsequently renewed by agreement between the insurer and policyholder in the commonwealth; any blanket or general policy of insurance described in subdivision (A), (C) or (D) of section 110 that provides hospital expense and surgical expense insurance and that is delivered, issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth ; or any employees' health and welfare fund that provides hospital expense and surgical expense benefits and that is delivered, issued or renewed to any person or group of persons in the commonwealth, shall provide to a commonwealth resident covered by the policy, coverage for a drug for the modification of multiple sclerosis that the individual has already been prescribed and has already been taking, upon receipt of documentation by the prescribing provider that 1) the member has been diagnosed with a form of multiple sclerosis, and 2) the

member has been stabilized or has achieved a positive clinical response as evidenced by low disease activity or improvement in symptoms on the drug.

Prior to receipt of the documentation described above, said policies shall provide a one-time 30-day transition fill, within the first 90 days of coverage under the plan, of an FDA-approved drug reimbursed through the commission's pharmacy benefit, or if a member's scheduled infusion occurs within the first 90 days of coverage under the plan, a one-time infusion of an FDA- approved drug reimbursed through the commission's medical benefit, for the modification of multiple sclerosis that the member has already been prescribed and on which the member is stable.

The benefits in this section shall not be subject to any greater deductible, coinsurance, copayments or out-of-pocket limits than the maximum deductible, coinsurance, copayments or out-of-pocket limits for other drugs for the modification of multiple sclerosis covered by the policy. This section shall also require coverage for such an ongoing drug treatment for the modification of multiple sclerosis under any non-group policy.

(b) Notwithstanding the requirements of paragraph (a), the transition period does not apply to the following: (i) new drugs for the modification of multiple sclerosis that have not been reviewed by the carrier's Pharmacy and Therapeutics (P & T) committee, (ii) products provided by sample, or (iii) products prescribed in a manner inconsistent with the FDA indication for the drug.

SECTION 3. Chapter 176A of the General Laws is hereby amended by inserting, after section 8KK, the following section:-

Section 8LL. (a) Any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed in the commonwealth shall provide as benefits to any individual subscribers or members within the commonwealth a drug for the modification of multiple sclerosis that the individual has already been prescribed and has already been taking, upon receipt of documentation by the prescribing provider that 1) the member has been diagnosed with a form of multiple sclerosis, and 2) the member has been stabilized or has achieved a positive clinical response as evidenced by low disease activity or improvement in symptoms on the drug.

Prior to receipt of the documentation described above, said contracts shall provide a one-time 30-day transition fill, within the first 90 days of coverage under the plan, of an FDA-approved drug reimbursed through the commission's pharmacy benefit, or if a member's scheduled infusion occurs within the first 90 days of coverage under the plan, a one-time infusion of an FDA- approved drug reimbursed through the commission's medical benefit, for the modification of multiple sclerosis that the member has already been prescribed and on which the member is stable.

The benefits in this section shall not be subject to any greater deductible, coinsurance, copayments or out-of-pocket limits than the maximum deductible, coinsurance, copayments or out-of-pocket limits for drugs for the modification of multiple sclerosis covered by the policy. This section shall also require coverage for such an ongoing drug treatment for the modification of multiple sclerosis under any non-group policy.

(b) Notwithstanding the requirements of paragraph (a), the transition period does not apply to the following: (i) new drugs for the modification of multiple sclerosis drugs that have

not been reviewed by the corporation's Pharmacy and Therapeutics (P & T) committee, (ii) products provided by sample, or (iii) products prescribed in a manner inconsistent with the FDA indication for the drug.

SECTION 4. 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 that shall be delivered, issued or renewed within the commonwealth shall provide as benefits to any individual subscriber or member within the commonwealth coverage for a drug for the modification of multiple sclerosis that the individual has already been prescribed and has already been taking, upon receipt of documentation by the prescribing provider that 1) the member has been diagnosed with a form of multiple sclerosis, and 2) the member has been stabilized or has achieved a positive clinical response as evidenced by low disease activity or improvement in symptoms on the drug.

Prior to receipt of the documentation described above, said certificates shall provide a one-time 30-day transition fill, within the first 90 days of coverage under the plan, of an FDA-approved drug reimbursed through the commission's pharmacy benefit, or if a member's scheduled infusion occurs within the first 90 days of coverage under the plan, a one-time infusion of an FDA- approved drug reimbursed through the commission's medical benefit, for the modification of multiple sclerosis that the member has already been prescribed and on which the member is stable.

The benefits in this section shall not be subject to any greater deductible, coinsurance, copayments or out-of-pocket limits than the maximum deductible, coinsurance, copayments or

out-of-pocket limits for other drugs for the modification of multiple sclerosis covered by the policy. This section shall also require coverage for such an ongoing drug treatment for the modification of multiple sclerosis under any non-group policy.

(b) Notwithstanding the requirements of paragraph (a), the transition period does not apply to the following: (i) new drugs for the modification of multiple sclerosis drugs that have not been reviewed by the carrier's Pharmacy and Therapeutics (P & T) committee, (ii) products provided by sample, or (iii) products prescribed in a manner inconsistent with the FDA indication for the drug.

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

Section 4DD. (a) An individual or group health maintenance contract shall provide coverage and benefits to any individual within the commonwealth for a drug for the modification of multiple sclerosis that the individual has already been prescribed and has already been taking, upon receipt of documentation by the prescribing provider that 1) the member has been diagnosed with a form of multiple sclerosis, and 2) the member has been stabilized or has achieved a positive clinical response as evidenced by low disease activity or improvement in symptoms on the drug.

Prior to receipt of the documentation described above, said policies shall provide a one-time 30-day transition fill, within the first 90 days of coverage under the plan, of an FDA-approved drug reimbursed through the commission's pharmacy benefit, or if a member's scheduled infusion occurs within the first 90 days of coverage under the plan, a one-time infusion of an FDA- approved drug reimbursed through the commission's medical benefit, for

the modification of multiple sclerosis that the member has already been prescribed and on which the member is stable.

The benefits in this section shall not be subject to any greater deductible, coinsurance, copayments or out-of-pocket limits than the maximum deductible, coinsurance, copayments or out-of-pocket limits for drugs for the modification of multiple sclerosis covered by the policy. This section shall also require coverage for such an ongoing drug treatment for the modification of multiple sclerosis under any non-group policy.

(b) Notwithstanding the requirements of paragraph (a), the transition period does not apply to the following: (i) new drugs for the modification of multiple sclerosis drugs that have not been reviewed by the carrier's Pharmacy and Therapeutics (P & T) committee, (ii) products provided by sample, or (iii) products prescribed in a manner inconsistent with the FDA indication for the drug.