SENATE DOCKET, NO. 8 FILED ON: 1/3/2019

SENATE . . . . . No. 561

The Commonwealth of Massachusetts

PRESENTED BY:

Brendan P. Crighton

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 empowering health care consumers.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
Brendan P. Crighton	*Third Essex*	
Jason M. Lewis	*Fifth Middlesex*	*1/30/2019*
Bruce E. Tarr	*First Essex and Middlesex*	*1/30/2019*
Patrick M. O'Connor	*Plymouth and Norfolk*	*1/30/2019*
Mathew J. Muratore	*1st Plymouth*	*1/30/2019*
Mike Connolly	*26th Middlesex*	*1/30/2019*
Anne M. Gobi	*Worcester, Hampden, Hampshire and Middlesex*	*1/30/2019*
Jack Patrick Lewis	*7th Middlesex*	*2/1/2019*
Sal N. DiDomenico	*Middlesex and Suffolk*	*2/1/2019*
Jennifer E. Benson	*37th Middlesex*	*2/13/2019*
Walter F. Timilty	*Norfolk, Bristol and Plymouth*	*3/29/2019*
Paul R. Feeney	*Bristol and Norfolk*	*9/30/2019*

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SENATE . . . . . No. 561

By Mr. Crighton, a petition (accompanied by bill, Senate, No. 561) of Brendan P. Crighton, Jason M. Lewis, Bruce E. Tarr, Patrick M. O'Connor and other members of the General Court for legislation to empower health care consumers. Financial Services.

The Commonwealth of Massachusetts

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

An Act empowering health care consumers.

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 47II the following section:-

Section 47JJ.

(a) Any policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the Commonwealth on or after January 1, 2018, shall:

(1) Provide notice in the evidence of coverage and disclosure form to enrollees regarding whether the plan uses a formulary. The notice shall include an explanation of what a formulary is, how the plan determines which prescription drugs are included or excluded, and how often the plan reviews the contents of the formulary.

(2) Post the formulary or formularies for each product offered by the plan on the plan's internet web site in a manner that is accessible and searchable by potential enrollees, enrollees, and providers.

(3) Update the formularies posted pursuant to paragraph (2) with any change to those formularies within 72 hours after making the change.

(4) Use a standard template developed pursuant to subsection (b) to display the formulary or formularies for each product offered by the plan.

(5) Include all of the following on any published formulary for any product offered by the plan, including, but not limited to, the formulary or formularies posted pursuant to paragraph (2):

(i) Any prior authorization, step therapy requirements, or utilization management requirements for each specific drug included on 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 the dollar cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan's formulary pursuant to paragraph (2) 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 clauses (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) the plan can provide a dollar amount range of cost sharing for a potential enrollee of each specific drug included on the formulary, as follows:

Under $100 – $.

$100-$250 – $$.

$251-$500 – $$$.

$500-$1,000 – $$$$.

Over $1,000 -- $$$$$

(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 subclause (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) The Division of Insurance shall develop a standard formulary template which a health care service plan shall use to comply with paragraph (4).

SECTION 2. 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 delivered or issued or renewed within the commonwealth on or after January 1, 2018, shall:

(1) Provide notice in the evidence of coverage and disclosure form to enrollees regarding whether the plan uses a formulary. The notice shall include an explanation of what a formulary is, how the plan determines which prescription drugs are included or excluded, and how often the plan reviews the contents of the formulary.

(2) Post the formulary or formularies for each product offered by the plan on the plan's internet web site in a manner that is accessible and searchable by potential enrollees, enrollees, and providers.

(3) Update the formularies posted pursuant to paragraph (2) with any change to those formularies within 72 hours after making the change.

(4) Use a standard template developed pursuant to subsection (b) to display the formulary or formularies for each product offered by the plan.

(5) Include all of the following on any published formulary for any product offered by the plan, including, but not limited to, the formulary or formularies posted pursuant to paragraph (2):

(i) Any prior authorization, step therapy requirements, or utilization management requirements for each specific drug included on 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 the dollar cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan's formulary pursuant to paragraph (2) 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 clauses (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) the plan can provide a dollar amount range of cost sharing for a potential enrollee of each specific drug included on the formulary, as follows:

Under $100 – $.

$100-$250 – $$.

$251-$500 – $$$.

$500-$1,000 – $$$$.

Over $1,000 -- $$$$$

(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 subclause (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) The Division of Insurance shall develop a standard formulary template which a health care service plan shall use to comply with paragraph (4).

SECTION 3. 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, 2018, shall:

(1) Provide notice in the evidence of coverage and disclosure form to enrollees regarding whether the plan uses a formulary. The notice shall include an explanation of what a formulary is, how the plan determines which prescription drugs are included or excluded, and how often the plan reviews the contents of the formulary.

(2) Post the formulary or formularies for each product offered by the plan on the plan's internet web site in a manner that is accessible and searchable by potential enrollees, enrollees, and providers.

(3) Update the formularies posted pursuant to paragraph (2) with any change to those formularies within 72 hours after making the change.

(4) Use a standard template developed pursuant to subsection (b) to display the formulary or formularies for each product offered by the plan.

(5) Include all of the following on any published formulary for any product offered by the plan, including, but not limited to, the formulary or formularies posted pursuant to paragraph (2):

(i) Any prior authorization, step therapy requirements, or utilization management requirements for each specific drug included on 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 the dollar cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan's formulary pursuant to paragraph (2) 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 clauses (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) the plan can provide a dollar amount range of cost sharing for a potential enrollee of each specific drug included on the formulary, as follows:

Under $100 – $.

$100-$250 – $$.

$251-$500 – $$$.

$500-$1,000 – $$$$.

Over $1,000 -- $$$$$

(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 subclause (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) The Division of Insurance shall develop a standard formulary template which a health care service plan shall use to comply with paragraph (4).

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

Section 4DD.

(a) Any individual or group health maintenance contract issued on or after January 1, 2018, shall:

(1) Provide notice in the evidence of coverage and disclosure form to enrollees regarding whether the plan uses a formulary. The notice shall include an explanation of what a formulary is, how the plan determines which prescription drugs are included or excluded, and how often the plan reviews the contents of the formulary.

(2) Post the formulary or formularies for each product offered by the plan on the plan's internet web site in a manner that is accessible and searchable by potential enrollees, enrollees, and providers.

(3) Update the formularies posted pursuant to paragraph (2) with any change to those formularies within 72 hours after making the change.

(4) Use a standard template developed pursuant to subsection (b) to display the formulary or formularies for each product offered by the plan.

(5) Include all of the following on any published formulary for any product offered by the plan, including, but not limited to, the formulary or formularies posted pursuant to paragraph (2):

(i) Any prior authorization, step therapy requirements, or utilization management requirements for each specific drug included on 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 the dollar cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan's formulary pursuant to paragraph (2) 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 clauses (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) the plan can provide a dollar amount range of cost sharing for a potential enrollee of each specific drug included on the formulary, as follows:

Under $100 – $.

$100-$250 – $$.

$251-$500 – $$$.

$500-$1,000 – $$$$.

Over $1,000 -- $$$$$

(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 subclause (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) The Division of Insurance shall develop a standard formulary template which a health care service plan shall use to comply with paragraph (4).

SECTION 5. 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, 2018, shall:

(1) Provide notice in the evidence of coverage and disclosure form to enrollees regarding whether the plan uses a formulary. The notice shall include an explanation of what a formulary is, how the plan determines which prescription drugs are included or excluded, and how often the plan reviews the contents of the formulary.

(2) Post the formulary or formularies for each product offered by the plan on the plan's internet web site in a manner that is accessible and searchable by potential enrollees, enrollees, and providers.

(3) Update the formularies posted pursuant to paragraph (2) with any change to those formularies within 72 hours after making the change.

(4) Use a standard template developed pursuant to subsection (b) to display the formulary or formularies for each product offered by the plan.

(5) Include all of the following on any published formulary for any product offered by the plan, including, but not limited to, the formulary or formularies posted pursuant to paragraph (2):

(i) Any prior authorization, step therapy requirements, or utilization management requirements for each specific drug included on 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 the dollar cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan's formulary pursuant to paragraph (2) 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 clauses (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) the plan can provide a dollar amount range of cost sharing for a potential enrollee of each specific drug included on the formulary, as follows:

Under $100 – $.

$100-$250 – $$.

$251-$500 – $$$.

$500-$1,000 – $$$$.

Over $1,000 -- $$$$$

(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 subclause (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) The Division of Insurance shall develop a standard formulary template which a health care service plan shall use to comply with paragraph (4).