SENATE . . . . . No. 2637

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Third General Court
(2023-2024)

SENATE, March 14, 2024.

The committee on Financial Services to whom was referred the petition (accompanied by bill, Senate, No. 616) of Julian Cyr for legislation relative to patient cost, benefit and coverage information, choice, and price transparency, report the accompanying bill (Senate, No. 2637).

For the committee,
Paul R. Feeney

FILED ON: 2/7/2024

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An Act relating to patient cost, benefit and coverage information, choice, and price transparency.

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 94C of the General Laws, is hereby amended by inserting after section 21C the following new section:-

Section 21D (a) For the purposes of this section, the following terms shall have the following meanings unless the context clearly requires otherwise:

“Cost-sharing information”, the amount an enrollee is required to pay in order to receive a drug that is covered under the enrollee’s health plan.

“Enrollee” a person who is receiving a health care benefit and assumes financial responsibility for outstanding costs associated with a prescription drug to treat a health condition for themself or a dependent member of their household.

"Health care benefit", a full or partial payment for health care services or the right under a contract or a certificate or policy of insurance to have a full or partial payment made by a health plan, as defined in this section, for a specified health care service.

“Health plan” any individual, general, blanket, or group policy of health, accident or sickness insurance issued by an insurer licensed under chapter one hundred and seventy-five or the laws of any other jurisdiction, as defined by Section 1 of Chapter 176M of the Massachusetts General Laws.

“Interoperability element”, hardware, software, integrated technologies or related licenses, technical information, privileges, rights, intellectual property, upgrades, or services that may be necessary to provide the data set forth in subsection (b)(3) in the requested format and consistent with subsection(b)(1).

“Patient” the enrollee or dependent family member of the enrollee who is treated by a prescribing physician.

“Personal Representative” a person, who has been identified and authorized as a third-party representative by the enrollee or by the commonwealth on behalf of the enrollee, to assist with decision making during their medical appointment, such as: a child accompanying an elderly parent, a healthcare proxy, a parent of a minor child, or a spouse.

“Pharmacy benefit manager” (a) For the purposes of this section, the term "pharmacy benefit manager" shall mean any person or entity that administers the (i) prescription drug, prescription device or pharmacist services or (ii) prescription drug and device and pharmacist services portion of a health benefit plan on behalf of plan sponsors, including, but not limited to, self-insured employers, insurance companies and labor unions. A health benefit plan that does not contract with a pharmacy benefit manager shall be considered a pharmacy benefit manager for the purposes of this section, unless specifically exempted.

"Prescribing practitioner" a physician, nurse practitioner, or physician's assistant who writes a prescription for a patient during the course of care for a medical condition.

(b) Any health plan or pharmacy benefit manager shall, upon request of the patient, enrollee, their prescribing practitioner, or their personal representative, furnish the cost, benefit, and coverage data set forth in subsection (3) to the enrollee, their prescribing practitioner, or their personal representative and shall ensure that such cost, benefit, and coverage data is (i) current as of one business day after any change is made; (ii) provided in real time to the provider in a clinical setting; and (iii) in the same format that the request is made by the enrollee or their prescribing practitioner.

(1) The format of the request shall use established industry content and transport standards published by:

(i) a standards developing organization accredited by the American National Standards Institute, included but not limited to, the National Council for Prescription Drug Programs, ASC X12, Health Level 7; or

(ii) a relevant federal or state agency or government body, included but not limited to the Center for Medicare & Medicaid Services or the Office of the National Coordinator for Health Information technology, The Commonwealth of Massachusetts Department of Public Health, Division of Insurance, Health Policy Commission, or Center for Health Information and Analysis.

(2) The following shall not be considered acceptable electronic formats pursuant to this section:

(i) a facsimile;

(ii) a proprietary payor or patient portal, unless it satisfies all of the requirements of section

(3) Upon such request, the following data shall be provided for any prescription drug covered under the enrollee's health plan:

(i) the patient's current eligibility information for such prescription drug;

(ii) a list of any clinically-appropriate alternatives to such prescription drug covered under the enrollee's current health plan;

(iii) cost-sharing information for such prescription drug and such clinically-appropriate alternatives, including a description of any variance in cost-sharing based on pharmacy, whether retail or mail order, or health care provider dispensing or administering such prescription drug or such alternatives;

(iv) any applicable utilization management requirements for such prescription drug or such clinically-appropriate alternatives, including prior authorization, step therapy, quantity limits, and site-of-service restrictions

(4) Any health plan or pharmacy benefit manager shall furnish the data set forth in subsection (b)(3), whether the request is made using the prescription drug's unique billing code, such as a National Drug Code or Healthcare Common Procedure Coding System code or descriptive term, such as the brand or generic name of the prescription drug.

(i) A health plan or pharmacy benefit manager shall not deny or delay a request as a method of blocking the data set forth in subsection (b)(3) from being shared based on how the drug was requested.

(c) Unless expressly prohibited by federal HIPAA law, any health plan or pharmacy benefit manager furnishing the data set forth in subsection (b)(3), shall not:

(1) restrict, prohibit, or otherwise hinder, in any way, a prescribing practitioner or health care professional from communicating or sharing:

(i) any of the data set forth in subsection (b)(3);

(ii) additional information on any lower-cost or clinically-appropriate alternatives, whether or not they are covered under the enrollee's plan; or

(iii) additional payment or cost-sharing information that may reduce the patient's out-of-pocket costs, such as cash price or patient assistance and support programs whether sponsored by a manufacturer, foundation, or other entity;

(2) Except as may be required by law, interfere with, prevent, or materially discourage access, exchange, or use of the data set forth in subsection (b)(3), which may include charging fees, not responding to a request at the time made where such a response is reasonably possible, implementing technology in nonstandard ways or instituting enrollee consent requirements, processes, policies, procedures, or renewals that are likely to substantially increase the complexity or burden of accessing, exchanging, or using such data; nor

(3) penalize a prescribing practitioner or professional for disclosing such information to an enrollee or their personal representative, or for prescribing, administering, or ordering a clinically appropriate or lower-cost alternative.

(4) Any health plan or pharmacy benefit manager shall treat an enrollee's identified personal representative as the enrollee for purposes of this section, provided that nothing in this section shall expand the legal relationship between an enrollee authorized representative and health plan.

(5) If under applicable law a person has authority to act on behalf of an enrollee in making decisions related to health care, a health plan or pharmacy benefit manager, or its affiliates or entities acting on its behalf, must treat such person as a personal representative under this section.

(d) Reimbursement for fees imposed for data access pursuant to this section may be negotiated and contracted between a health plan or pharmacy benefit manager and a prescribing provider upon mutual agreement.