

# SENATE . . . . . No. 605

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## 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:                        |                  |
|----------------------------|------------------------------------------|------------------|
| <i>Brendan P. Crighton</i> | <i>Third Essex</i>                       |                  |
| <i>Joanne M. Comerford</i> | <i>Hampshire, Franklin and Worcester</i> | <i>1/27/2023</i> |
| <i>Michael O. Moore</i>    | <i>Second Worcester</i>                  | <i>2/8/2023</i>  |
| <i>Michael D. Brady</i>    | <i>Second Plymouth and Norfolk</i>       | <i>2/8/2023</i>  |
| <i>Patrick M. O'Connor</i> | <i>First Plymouth and Norfolk</i>        | <i>2/14/2023</i> |

# SENATE . . . . . No. 605

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By Mr. Crighton, a petition (accompanied by bill, Senate, No. 605) of Brendan P. Crighton, Joanne M. Comerford, Michael O. Moore, Michael D. Brady and others for legislation to empower health care consumers. Financial Services.

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[SIMILAR MATTER FILED IN PREVIOUS SESSION  
SEE SENATE, NO. 642 OF 2021-2022.]

## The Commonwealth of Massachusetts

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

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:*

1           SECTION 1. Chapter 175 of the General Laws is hereby amended by inserting after  
2           section 47II the following section:-

3           Section 47JJ.

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

6           (1) Provide notice in the evidence of coverage and disclosure form to enrollees regarding  
7           whether the plan uses a formulary. The notice shall include an explanation of what a formulary  
8           is, how the plan determines which prescription drugs are included or excluded, and how often the  
9           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:

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

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

34 Under \$100 – \$.

35 \$100-\$250 – \$\$.

36 \$251-\$500 – \$\$\$.

37 \$500-\$1,000 – \$\$\$\$.

38 Over \$1,000 -- \$\$\$\$\$

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

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

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

47 SECTION 2. Chapter 176A of the General Laws is hereby amended by inserting after  
48 section 8KK the following section:-

49 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 – \$\$\$.

130           \$500-\$1,000 – \$\$\$\$.

131           Over \$1,000 -- \$\$\$\$\$

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

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

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

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

142           Section 4DD.

143           (a) Any individual or group health maintenance contract issued on or after January 1,  
144 2018, shall:

145           (1) Provide notice in the evidence of coverage and disclosure form to enrollees regarding  
146 whether the plan uses a formulary. The notice shall include an explanation of what a formulary  
147 is, how the plan determines which prescription drugs are included or excluded, and how often the  
148 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:

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

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

173 Under \$100 – \$.

174 \$100-\$250 – \$\$.

175 \$251-\$500 – \$\$\$.

176 \$500-\$1,000 – \$\$\$\$.

177 Over \$1,000 -- \$\$\$\$\$

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

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

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

186 SECTION 5. Chapter 32A of the General Laws is hereby amended by inserting after  
187 section 27 the following section:-

188 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).

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

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