

**HOUSE . . . . . No. 1131**

---

**The Commonwealth of Massachusetts**

PRESENTED BY:

*Jeffrey N. Roy*

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

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
<i>Jeffrey N. Roy</i>	<i>10th Norfolk</i>	<i>1/12/2023</i>

**HOUSE . . . . . No. 1131**

By Representative Roy of Franklin, a petition (accompanied by bill, House, No. 1131) of Jeffrey N. Roy relative to patient cost, benefit, and coverage information, choice, and price transparency. Financial Services.

**The Commonwealth of Massachusetts**

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

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:*

1 SECTION 1. Chapter 94C of the General Laws, is hereby amended by inserting after  
2 section 21C the following new section:-

3 Section 21D

4 (a) for the purposes of this section, the following terms shall have the following  
5 meanings unless the context clearly requires otherwise:

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

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

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

14 "Health plan" any insurance company authorized to provide health insurance in this state  
15 or any legal entity which is self-insured and providing health care benefits to its employees.

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

20 "Patient" the enrollee or dependent family member of the enrollee who is treated by a  
21 prescribing physician.

22 "Personal Representative" a person, who has been identified by the enrollee or by the  
23 commonwealth on behalf of the enrollee, to assist with decision making during their medical  
24 appointment, such as: a child accompanying an elderly parent, a healthcare proxy, a parent of a  
25 minor child, or a spouse.

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

33           “Prescribing practitioner” a physician, nurse practitioner, or physician’s assistant who  
34 writes a prescription for a patient during the course of care for a medical condition.

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

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

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

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

51           (2)     a facsimile, proprietary payor or patient portal, or other electronic form other than  
52 as required by section (b) shall not be considered acceptable electronic formats pursuant to this  
53 section.

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

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

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

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

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

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

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

73           (c)     any health plan or pharmacy benefit manager furnishing the data set forth in  
74 subsection (b)(3), shall not:

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

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

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

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

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

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

92 (4) any health plan or pharmacy benefit manager shall treat an enrollee's identified  
93 personal representative as the enrollee for purposes of this section.

94 (5) if under applicable law a person has authority to act on behalf of an enrollee in  
95 making decisions related to health care, a health plan or pharmacy benefit manager, or its

96 affiliates or entities acting on its behalf, must treat such person as a personal representative under  
97 this section.

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