

**HOUSE . . . . . No. 792**

The Commonwealth of Massachusetts

PRESENTED BY:

*Jennifer E. Benson*

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 relative to ensuring transparency of health plan formularies.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
<i>Jennifer E. Benson</i>	<i>37th Middlesex</i>
<i>Carolyn C. Dykema</i>	<i>8th Middlesex</i>
<i>Tricia Farley-Bouvier</i>	<i>3rd Berkshire</i>
<i>James R. Miceli</i>	<i>19th Middlesex</i>
<i>Michael O. Moore</i>	<i>Second Worcester</i>
<i>Brian M. Ashe</i>	<i>2nd Hampden</i>
<i>Ruth B. Balsler</i>	<i>12th Middlesex</i>
<i>Denise Provost</i>	<i>27th Middlesex</i>
<i>Jason M. Lewis</i>	<i>Fifth Middlesex</i>
<i>Barbara L'Italien</i>	<i>Second Essex and Middlesex</i>
<i>Tom Sannicandro</i>	<i>7th Middlesex</i>
<i>Daniel J. Ryan</i>	<i>2nd Suffolk</i>
<i>Bruce E. Tarr</i>	<i>First Essex and Middlesex</i>
<i>Joseph W. McGonagle, Jr.</i>	<i>28th Middlesex</i>
<i>Marcos A. Devers</i>	<i>16th Essex</i>
<i>Gailanne M. Cariddi</i>	<i>1st Berkshire</i>
<i>Christine P. Barber</i>	<i>34th Middlesex</i>
<i>Kevin J. Kuros</i>	<i>8th Worcester</i>

*James Arciero*  
*Kay Khan*

*2nd Middlesex*  
*11th Middlesex*

**HOUSE . . . . . No. 792**

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By Ms. Benson of Lunenburg, a petition (accompanied by bill, House, No. 792) of Jennifer E. Benson and others for legislation to provide transparency in the data contained in the payer and provider claims database. Financial Services.

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The Commonwealth of Massachusetts

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**In the One Hundred and Eighty-Ninth General Court  
(2015-2016)**  
\_\_\_\_\_

An Act relative to ensuring transparency of health plan formularies.

*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 110M the following section:-

3 Section 110N. Any policy, contract, agreement, plan or certificate of insurance issued,  
4 delivered or renewed within the commonwealth on or after January 1, 2017, shall:

5 (a) Post the formulary for the health plan on the carrier's web site in a manner that  
6 is accessible and searchable by enrollees, potential enrollees, and providers;

7 (b) Update the formulary posted pursuant to subsection (1)(a) of this section no  
8 later than twenty-four hours after making a change to the formulary;

9 (c) Use a standard template (to be developed) pursuant to subsection (5) to display the  
10 formulary or formularies for each product offered by the plan and

11 (d) Include on any published formulary for the plan, including but not limited to  
12 the formulary posted pursuant to subsection (1)(a) of this section, the following:

13 (i) Any utilization management edits -- including prior authorization, step  
14 therapy edits, quantity limits, or other requirements -- for each specific drug included in the  
15 formulary;

16 (ii) If the plan uses a Tier-based formulary, the plan shall specify for each drug listed on  
17 the formulary the specific Tier the drug occupies and list the specific co-payments for each Tier  
18 in the evidence of coverage;

19 (iii) For prescription drugs covered under the plans medical benefit and typically  
20 administered by a provider, plans must disclose to enrollees and potential enrollees, all covered  
21 drugs and any cost-sharing imposed on such drugs. This information can be provided to the  
22 consumer as part of the plan's formulary pursuant to section (1) or via a toll free number that is  
23 staffed at least during normal business hours;

24 (iv) For each prescription drug included on the formulary under subsection (ii) or (iii) that  
25 is subject to a coinsurance and dispensed at an in-network pharmacy the plan must:

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

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

29 (1) Under one hundred dollars: \$;

30 (2) One hundred dollars to two hundred fifty dollars: \$\$;

31 (3) Two hundred fifty-one dollars to five hundred dollars: \$\$\$; and

32 (4) Five hundred dollars to one thousand dollars: \$\$\$\$.

33 (5) Over one thousand dollars: \$\$\$\$\$

34 (v) If the carrier allows the option for mail order pharmacy, the carrier  
35 separately must list the range of cost-sharing for a potential enrollee if the potential enrollee  
36 purchases the drug through a mail order facility utilizing the same ranges as provided in section  
37 (d)(v)(B).

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

41 (2) Each carrier offering or renewing a health plan on or after January 1, 2017, must  
42 make available to current and potential enrollees the information mandated under section (1) and  
43 (2). The information must be available prior to the beginning of the open enrollment period and  
44 must be done via a public website and through a toll free number that is posted on the carrier's  
45 website.

46 (3) Each carrier offering or renewing a health plan on or after January 1, 2017, must, no  
47 later than thirty days after the offer or renewal date, attest to the office of the insurance  
48 commissioner that the carrier has satisfied the requirements of this section.

49 (4) The Division of Insurance may develop a standard formulary template. If the  
50 department develops this template, a health care service plan shall use the template to comply  
51 with paragraph (c) of section 1.

52 (5) For purposes of this section, "formulary" means the complete list of drugs preferred  
53 for use and eligible for coverage under the health plan.

54 SECTION 2. Chapter 176A of the General Laws is hereby amended by inserting after  
55 section 8AA the following section:-

56 Section 8BB. Any contract between a subscriber and the corporation under an individual  
57 or group hospital service plan delivered or issued or renewed within the commonwealth on or  
58 after January 1, 2017, shall:

59 (a) Post the formulary for the health plan on the carrier's web site in a manner that  
60 is accessible and searchable by enrollees, potential enrollees, and providers;

61 (b) Update the formulary posted pursuant to subsection (1)(a) of this section no  
62 later than twenty-four hours after making a change to the formulary;

63 (c) Use a standard template (to be developed) pursuant to subsection (5) to display the  
64 formulary or formularies for each product offered by the plan and

65 (d) Include on any published formulary for the plan, including but not limited to  
66 the formulary posted pursuant to subsection (1)(a) of this section, the following:

67 (i) Any utilization management edits -- including prior authorization, step  
68 therapy edits, quantity limits, or other requirements -- for each specific drug included in the  
69 formulary;

70 (ii) If the plan uses a Tier-based formulary, the plan shall specify for each drug listed on  
71 the formulary the specific Tier the drug occupies and list the specific co-payments for each Tier  
72 in the evidence of coverage;

73 (iii) For prescription drugs covered under the plans medical benefit and typically  
74 administered by a provider, plans must disclose to enrollees and potential enrollees, all covered  
75 drugs and any cost-sharing imposed on such drugs. This information can be provided to the  
76 consumer as part of the plan's formulary pursuant to section (1) or via a toll free number that is  
77 staffed at least during normal business hours;

78 (iv) For each prescription drug included on the formulary under subsection (ii) or (iii) that  
79 is subject to a coinsurance and dispensed at an in-network pharmacy the plan must:

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

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

83 (1) Under one hundred dollars: \$;

84 (2) One hundred dollars to two hundred fifty dollars: \$\$;

85 (3) Two hundred fifty-one dollars to five hundred dollars: \$\$\$; and

86 (4) Five hundred dollars to one thousand dollars: \$\$\$\$.

87 (5) Over one thousand dollars: \$\$\$\$\$

88 (v) If the carrier allows the option for mail order pharmacy, the carrier  
89 separately must list the range of cost-sharing for a potential enrollee if the potential enrollee  
90 purchases the drug through a mail order facility utilizing the same ranges as provided in section  
91 (d)(v)(B).

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

95 (2) Each carrier offering or renewing a health plan on or after January 1, 2017, must  
96 make available to current and potential enrollees the information mandated under section (1) and  
97 (2). The information must be available prior to the beginning of the open enrollment period and  
98 must be done via a public website and through a toll free number that is posted on the carrier's  
99 website.

100 (3) Each carrier offering or renewing a health plan on or after January 1, 2017, must, no  
101 later than thirty days after the offer or renewal date, attest to the office of the insurance  
102 commissioner that the carrier has satisfied the requirements of this section.

103 (4) The Division of Insurance may develop a standard formulary template. If the  
104 department develops this template, a health care service plan shall use the template to comply  
105 with paragraph (c) of section 1.

106 (5) For purposes of this section, "formulary" means the complete list of drugs preferred  
107 for use and eligible for coverage under the health plan.

108 SECTION 3. Chapter 176B of the General Laws is hereby amended by inserting after  
109 section 4AA the following section:-

110 Section 4BB. Any subscription certificate under an individual or group medical service  
111 agreement delivered, issued or renewed within the commonwealth on or after January 1, 2017,  
112 shall:



113 (a) Post the formulary for the health plan on the carrier's web site in a manner that  
114 is accessible and searchable by enrollees, potential enrollees, and providers;

115 (b) Update the formulary posted pursuant to subsection (1)(a) of this section no  
116 later than twenty-four hours after making a change to the formulary;

117 (c) Use a standard template (to be developed) pursuant to subsection (5) to display the  
118 formulary or formularies for each product offered by the plan and

119 (d) Include on any published formulary for the plan, including but not limited to  
120 the formulary posted pursuant to subsection (1)(a) of this section, the following:

121 (i) Any utilization management edits -- including prior authorization, step  
122 therapy edits, quantity limits, or other requirements -- for each specific drug included in the  
123 formulary;

124 (ii) If the plan uses a Tier-based formulary, the plan shall specify for each drug listed on  
125 the formulary the specific Tier the drug occupies and list the specific co-payments for each Tier  
126 in the evidence of coverage;

127 (iii) For prescription drugs covered under the plans medical benefit and typically  
128 administered by a provider, plans must disclose to enrollees and potential enrollees, all covered  
129 drugs and any cost-sharing imposed on such drugs. This information can be provided to the  
130 consumer as part of the plan's formulary pursuant to section (1) or via a toll free number that is  
131 staffed at least during normal business hours;

132 (iv) For each prescription drug included on the formulary under subsection (ii) or (iii) that  
133 is subject to a coinsurance and dispensed at an in-network pharmacy the plan must:

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

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

137 (1) Under one hundred dollars: \$;

138 (2) One hundred dollars to two hundred fifty dollars: \$\$;

139 (3) Two hundred fifty-one dollars to five hundred dollars: \$\$\$; and

140 (4) Five hundred dollars to one thousand dollars: \$\$\$\$.

141 (5) Over one thousand dollars: \$\$\$\$\$

142 (v) If the carrier allows the option for mail order pharmacy, the carrier  
143 separately must list the range of cost-sharing for a potential enrollee if the potential enrollee  
144 purchases the drug through a mail order facility utilizing the same ranges as provided in section  
145 (d)(v)(B).

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

149 (2) Each carrier offering or renewing a health plan on or after January 1, 2017, must  
150 make available to current and potential enrollees the information mandated under section (1) and  
151 (2). The information must be available prior to the beginning of the open enrollment period and  
152 must be done via a public website and through a toll free number that is posted on the carrier's  
153 website.

154 (3) Each carrier offering or renewing a health plan on or after January 1, 2017, must, no  
155 later than thirty days after the offer or renewal date, attest to the office of the insurance  
156 commissioner that the carrier has satisfied the requirements of this section.

157 (4) The Division of Insurance may develop a standard formulary template. If the  
158 department develops this template, a health care service plan shall use the template to comply  
159 with paragraph (c) of section 1.

160 (5) For purposes of this section, "formulary" means the complete list of drugs preferred  
161 for use and eligible for coverage under the health plan.

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

164 Section 4T. Any individual or group health maintenance contract issued on or after  
165 January 1, 2017, shall:

166 (a) Post the formulary for the health plan on the carrier's web site in a manner that  
167 is accessible and searchable by enrollees, potential enrollees, and providers;

168 (b) Update the formulary posted pursuant to subsection (1)(a) of this section no  
169 later than twenty-four hours after making a change to the formulary;

170 (c) Use a standard template (to be developed) pursuant to subsection (5) to display the  
171 formulary or formularies for each product offered by the plan and

172 (d) Include on any published formulary for the plan, including but not limited to  
173 the formulary posted pursuant to subsection (1)(a) of this section, the following:

174 (i) Any utilization management edits -- including prior authorization, step  
175 therapy edits, quantity limits, or other requirements -- for each specific drug included in the  
176 formulary;

177 (ii) If the plan uses a Tier-based formulary, the plan shall specify for each drug listed on  
178 the formulary the specific Tier the drug occupies and list the specific co-payments for each Tier  
179 in the evidence of coverage;

180 (iii) For prescription drugs covered under the plans medical benefit and typically  
181 administered by a provider, plans must disclose to enrollees and potential enrollees, all covered  
182 drugs and any cost-sharing imposed on such drugs. This information can be provided to the  
183 consumer as part of the plan's formulary pursuant to section (1) or via a toll free number that is  
184 staffed at least during normal business hours;

185 (iv) For each prescription drug included on the formulary under subsection (ii) or (iii) that  
186 is subject to a coinsurance and dispensed at an in-network pharmacy the plan must:

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

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

190 (1) Under one hundred dollars: \$;

191 (2) One hundred dollars to two hundred fifty dollars: \$\$;

192 (3) Two hundred fifty-one dollars to five hundred dollars: \$\$\$; and

193 (4) Five hundred dollars to one thousand dollars: \$\$\$\$.

194 (5) Over one thousand dollars: \$\$\$\$

195 (v) If the carrier allows the option for mail order pharmacy, the carrier  
196 separately must list the range of cost-sharing for a potential enrollee if the potential enrollee  
197 purchases the drug through a mail order facility utilizing the same ranges as provided in section  
198 (d)(v)(B).

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

202 (2) Each carrier offering or renewing a health plan on or after January 1, 2017, must  
203 make available to current and potential enrollees the information mandated under section (1) and  
204 (2). The information must be available prior to the beginning of the open enrollment period and  
205 must be done via a public website and through a toll free number that is posted on the carrier's  
206 website.

207 (3) Each carrier offering or renewing a health plan on or after January 1, 2017, must, no  
208 later than thirty days after the offer or renewal date, attest to the office of the insurance  
209 commissioner that the carrier has satisfied the requirements of this section.

210 (4) The Division of Insurance may develop a standard formulary template. If the  
211 department develops this template, a health care service plan shall use the template to comply  
212 with paragraph (c) of section 1.

213 (5) For purposes of this section, "formulary" means the complete list of drugs preferred  
214 for use and eligible for coverage under the health plan.

215 SECTION 5. Chapter 32A of the General Laws is hereby amended by inserting after  
216 section 23 the following section:-

217 Section 24. Any coverage offered by the commission to any active or retired employee of  
218 the commonwealth who is insured under the group insurance commission on or after January 1,  
219 2017, shall:

220 (a) Post the formulary for the health plan on the carrier's web site in a manner that  
221 is accessible and searchable by enrollees, potential enrollees, and providers;

222 (b) Update the formulary posted pursuant to subsection (1)(a) of this section no  
223 later than twenty-four hours after making a change to the formulary;

224 (c) Use a standard template (to be developed) pursuant to subsection (5) to display the  
225 formulary or formularies for each product offered by the plan and

226 (d) Include on any published formulary for the plan, including but not limited to  
227 the formulary posted pursuant to subsection (1)(a) of this section, the following:

228 (i) Any utilization management edits -- including prior authorization, step  
229 therapy edits, quantity limits, or other requirements -- for each specific drug included in the  
230 formulary;

231 (ii) If the plan uses a Tier-based formulary, the plan shall specify for each drug listed on  
232 the formulary the specific Tier the drug occupies and list the specific co-payments for each Tier  
233 in the evidence of coverage;

234 (iii) For prescription drugs covered under the plans medical benefit and typically  
235 administered by a provider, plans must disclose to enrollees and potential enrollees, all covered

236 drugs and any cost-sharing imposed on such drugs. This information can be provided to the  
237 consumer as part of the plan's formulary pursuant to section (1) or via a toll free number that is  
238 staffed at least during normal business hours;

239 (iv) For each prescription drug included on the formulary under subsection (ii) or (iii) that  
240 is subject to a coinsurance and dispensed at an in-network pharmacy the plan must:

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

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

244 (1) Under one hundred dollars: \$;

245 (2) One hundred dollars to two hundred fifty dollars: \$\$;

246 (3) Two hundred fifty-one dollars to five hundred dollars: \$\$\$; and

247 (4) Five hundred dollars to one thousand dollars: \$\$\$\$.

248 (5) Over one thousand dollars: \$\$\$\$\$.

249 (v) If the carrier allows the option for mail order pharmacy, the carrier  
250 separately must list the range of cost-sharing for a potential enrollee if the potential enrollee  
251 purchases the drug through a mail order facility utilizing the same ranges as provided in section  
252 (d)(v)(B).

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

256 (2) Each carrier offering or renewing a health plan on or after January 1, 2017, must  
257 make available to current and potential enrollees the information mandated under section (1) and  
258 (2). The information must be available prior to the beginning of the open enrollment period and  
259 must be done via a public website and through a toll free number that is posted on the carrier's  
260 website.

261 (3) Each carrier offering or renewing a health plan on or after January 1, 2017, must, no  
262 later than thirty days after the offer or renewal date, attest to the office of the insurance  
263 commissioner that the carrier has satisfied the requirements of this section.

264 (4) The Division of Insurance may develop a standard formulary template. If the  
265 department develops this template, a health care service plan shall use the template to comply  
266 with paragraph (c) of section 1.

267 (5) For purposes of this section, "formulary" means the complete list of drugs preferred  
268 for use and eligible for coverage under the health plan.