HOUSE DOCKET, NO. 2912 FILED ON: 1/16/2015

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

James Arciero	*2nd Middlesex*
Kay Khan	*11th Middlesex*

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HOUSE . . . . . No. 792

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.

The Commonwealth of Massachusetts

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:

SECTION 1. Chapter 175 of the General Laws is hereby amended by inserting after section 110M the following section:-

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

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

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

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

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

(i) Any utilization management edits –- including prior authorization, step therapy edits, quantity limits, or other requirements -- for each specific drug included in 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 any cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan's formulary pursuant to section (1) 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 subsection (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) provide a dollar amount range of cost sharing for a potential enrollee of each specific drug included on the formulary, as follows:

(1) Under one hundred dollars: $;

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

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

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

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

(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 section (d)(v)(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

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

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

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

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

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

Section 8BB. 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, 2017, shall:

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

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

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

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

(i) Any utilization management edits –- including prior authorization, step therapy edits, quantity limits, or other requirements -- for each specific drug included in 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 any cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan's formulary pursuant to section (1) 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 subsection (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) provide a dollar amount range of cost sharing for a potential enrollee of each specific drug included on the formulary, as follows:

(1) Under one hundred dollars: $;

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

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

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

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

(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 section (d)(v)(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

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

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

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

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

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

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

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

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

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

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

(i) Any utilization management edits –- including prior authorization, step therapy edits, quantity limits, or other requirements -- for each specific drug included in 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 any cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan’s formulary pursuant to section (1) 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 subsection (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) provide a dollar amount range of cost sharing for a potential enrollee of each specific drug included on the formulary, as follows:

(1) Under one hundred dollars: $;

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

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

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

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

(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 section (d)(v)(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

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

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

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

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

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

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

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

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

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

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

(i) Any utilization management edits –- including prior authorization, step therapy edits, quantity limits, or other requirements -- for each specific drug included in 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 any cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan's formulary pursuant to section (1) 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 subsection (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) provide a dollar amount range of cost sharing for a potential enrollee of each specific drug included on the formulary, as follows:

(1) Under one hundred dollars: $;

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

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

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

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

(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 section (d)(v)(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

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

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

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

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

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

Section 24. 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, 2017, shall:

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

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

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

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

(i) Any utilization management edits –- including prior authorization, step therapy edits, quantity limits, or other requirements -- for each specific drug included in 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 any cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan's formulary pursuant to section (1) 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 subsection (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) provide a dollar amount range of cost sharing for a potential enrollee of each specific drug included on the formulary, as follows:

(1) Under one hundred dollars: $;

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

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

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

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

(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 section (d)(v)(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

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

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

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

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