

**SENATE . . . . . No. 541**

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The Commonwealth of Massachusetts

PRESENTED BY:

*Anthony W. Petruccelli*

*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 concerning out-of-pocket expenses for prescription drug coverage.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
<i>Anthony W. Petruccelli</i>	<i>First Suffolk and Middlesex</i>
<i>Barbara L'Italien</i>	<i>Second Essex and Middlesex</i>
<i>Jeffrey N. Roy</i>	<i>10th Norfolk</i>

**SENATE . . . . . No. 541**

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By Mr. Petruccelli, a petition (accompanied by bill, Senate, No. 541) of Anthony W. Petruccelli, Barbara L'Italien and Jeffrey N. Roy for legislation relative to out-of-pocket expenses for prescription drug coverage. 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)**  
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An Act concerning out-of-pocket expenses for prescription drug coverage.

*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 47DD the following section:-

3 Section 47EE. (a) As used in this section the following words shall, unless the context  
4 clearly requires otherwise, have the following meanings:-

5 "Commissioner" means the Commissioner of the Division of Insurance.

6 "Cost-sharing" means coinsurance, copayments, deductibles, or any other out-of-pocket  
7 expense.

8 "Deductible" means the amount of covered expenses which must be accumulated  
9 annually before benefits become payable as additional covered expenses incurred.

10 “Tiered formulary” means a formulary that provides coverage for prescription drugs as  
11 part of a health plan for which cost sharing, deductibles or coinsurance obligations are  
12 determined by category or tier of prescription drugs, that includes at least two different tiers.

13 (b) No policy, contract, agreement, plan or certificate of insurance delivered, issued for  
14 delivery, renewed, amended or continued in this state that provides coverage for prescription  
15 drugs may:

16 (1) Impose any cost-sharing that exceeds one hundred dollars per thirty-day supply for a  
17 covered prescription drug; or

18 (2) Place all drugs in a given class on the highest cost-sharing tier in a tiered formulary.

19 (c) The provisions of subsection (b) of this section shall apply pre-deductible.

20 (d) The provisions of subsection (b) of this section shall apply to a high deductible health  
21 plan after the minimum deductible amounts required for such plans, as set forth in the Internal  
22 Revenue Code, 26 U.S.C. 223(c)(2)(A)(1), are met.

23 (e) A health plan that provides coverage for prescription drugs shall allow enrollees to  
24 request an exception to the formulary. Under such an exception, a non-formulary drug could be  
25 deemed covered under the formulary if the prescribing physician determines that the formulary  
26 drug for treatment of the same condition either would not be as effective for the individual or  
27 would have adverse effects for the individual, or both.

28 (f) In the event an enrollee is denied an exception as provided by subsection (e) of this  
29 section, such denial shall be considered an adverse determination and will be subject to the  
30 health plan internal review process set forth in M.G.L. Ch. 176O.

31 (g) Nothing in this section shall be construed to require a health plan to:

32 (1) Provide coverage for any additional drugs not otherwise required by law;

33 (2) Implement specific utilization management techniques, such as prior authorization or  
34 step therapy; or

35 (3) Cease utilization of tiered cost-sharing structures, including those strategies used to  
36 incent use of preventive services, disease management, and low-cost treatment options.

37 Section 2. Chapter 176A of the General Laws is hereby amended by inserting after  
38 section 8FF the following section:-

39 Section 8GG. (a) As used in this section the following words shall, unless the context  
40 clearly requires otherwise, have the following meanings:-

41 “Commissioner” means the Commissioner of the Division of Insurance.

42 “Cost-sharing” means coinsurance, copayments, deductibles, or any other out-of-pocket  
43 expense.

44 “Deductible” means the amount of covered expenses which must be accumulated  
45 annually before benefits become payable as additional covered expenses incurred.

46 “Tiered formulary” means a formulary that provides coverage for prescription drugs as  
47 part of a health plan for which cost sharing, deductibles or coinsurance obligations are  
48 determined by category or tier of prescription drugs, that includes at least two different tiers.

49 (b) No contract between a subscriber and the corporation under an individual or group  
50 hospital service plan delivered, issued for delivery, renewed, amended or continued in this state  
51 that provides coverage for prescription drugs may:

52 (1) Impose any cost-sharing that exceeds one hundred dollars per thirty-day supply for a  
53 covered prescription drug; or

54 (2) Place all drugs in a given class on the highest cost-sharing tier in a tiered formulary.

55 (c) The provisions of subsection (b) of this section shall apply pre-deductible.

56 (d) The provisions of subsection (b) of this section shall apply to a high deductible health  
57 plan after the minimum deductible amounts required for such plans, as set forth in the Internal  
58 Revenue Code, 26 U.S.C. 223(c)(2)(A)(1), are met.

59 (e) A health plan that provides coverage for prescription drugs shall allow enrollees to  
60 request an exception to the formulary. Under such an exception, a non-formulary drug could be  
61 deemed covered under the formulary if the prescribing physician determines that the formulary  
62 drug for treatment of the same condition either would not be as effective for the individual or  
63 would have adverse effects for the individual, or both.

64 (f) In the event an enrollee is denied an exception as provided by subsection (e) of this  
65 section, such denial shall be considered an adverse determination and will be subject to the  
66 health plan internal review process set forth in M.G.L. Ch. 176O.

67 (g) Nothing in this section shall be construed to require a health plan to:

68 (1) Provide coverage for any additional drugs not otherwise required by law;

69 (2) Implement specific utilization management techniques, such as prior authorization or  
70 step therapy; or

71 (3) Cease utilization of tiered cost-sharing structures, including those strategies used to  
72 incent use of preventive services, disease management, and low-cost treatment options.

73 Section 3. Chapter 176B of the General Laws is hereby amended by inserting after  
74 section 4FF the following section:-

75 Section 4GG. (a) As used in this section the following words shall, unless the context  
76 clearly requires otherwise, have the following meanings:-

77 “Commissioner” means the Commissioner of the Division of Insurance.

78 “Cost-sharing” means coinsurance, copayments, deductibles, or any other out-of-pocket  
79 expense.

80 “Deductible” means the amount of covered expenses which must be accumulated  
81 annually before benefits become payable as additional covered expenses incurred.

82 “Tiered formulary” means a formulary that provides coverage for prescription drugs as  
83 part of a health plan for which cost sharing, deductibles or coinsurance obligations are  
84 determined by category or tier of prescription drugs, that includes at least two different tiers.

85 (b) No subscription certificate under an individual or group medical service agreement  
86 delivered, issued for delivery, renewed, amended or continued in this state that provides  
87 coverage for prescription drugs may:

88 (1) Impose any cost-sharing that exceeds one hundred dollars per thirty-day supply for a  
89 covered prescription drug; or

90 (2) Place all drugs in a given class on the highest cost-sharing tier in a tiered formulary.

91 (c) The provisions of subsection (b) of this section shall apply pre-deductible.

92 (d) The provisions of subsection (b) of this section shall apply to a high deductible health  
93 plan after the minimum deductible amounts required for such plans, as set forth in the Internal  
94 Revenue Code, 26 U.S.C. 223(c)(2)(A)(1), are met.

95 (e) A health plan that provides coverage for prescription drugs shall allow enrollees to  
96 request an exception to the formulary. Under such an exception, a non-formulary drug could be  
97 deemed covered under the formulary if the prescribing physician determines that the formulary  
98 drug for treatment of the same condition either would not be as effective for the individual or  
99 would have adverse effects for the individual, or both.

100 (f) In the event an enrollee is denied an exception as provided by subsection (e) of this  
101 section, such denial shall be considered an adverse determination and will be subject to the  
102 health plan internal review process set forth in M.G.L. Ch. 176O.

103 (g) Nothing in this section shall be construed to require a health plan to:

104 (1) Provide coverage for any additional drugs not otherwise required by law;

105 (2) Implement specific utilization management techniques, such as prior authorization or  
106 step therapy; or

107 (3) Cease utilization of tiered cost-sharing structures, including those strategies used to  
108 incent use of preventive services, disease management, and low-cost treatment options.

109 Section 4. Chapter 176G of the General Laws is hereby amended by inserting after  
110 section 4X the following section:-

111 Section 4Y. (a) As used in this section the following words shall, unless the context  
112 clearly requires otherwise, have the following meanings:

113 “Commissioner” means the Commissioner of the Division of Insurance.

114 “Cost-sharing” means coinsurance, copayments, deductibles, or any other out-of-pocket  
115 expense.

116 “Deductible” means the amount of covered expenses which must be accumulated  
117 annually before benefits become payable as additional covered expenses incurred.

118 “Tiered formulary” means a formulary that provides coverage for prescription drugs as  
119 part of a health plan for which cost sharing, deductibles or coinsurance obligations are  
120 determined by category or tier of prescription drugs, that includes at least two different tiers.

121 (b) No s individual or group health maintenance delivered, issued for delivery, renewed,  
122 amended or continued in this state that provides coverage for prescription drugs may:

123 (1) Impose any cost-sharing that exceeds one hundred dollars per thirty-day supply for a  
124 covered prescription drug; or

125 (2) Place all drugs in a given class on the highest cost-sharing tier in a tiered formulary.

126 (c) The provisions of subsection (b) of this section shall apply pre-deductible.



127 (d) The provisions of subsection (b) of this section shall apply to a high deductible health  
128 plan after the minimum deductible amounts required for such plans, as set forth in the Internal  
129 Revenue Code, 26 U.S.C. 223(c)(2)(A)(1), are met.

130 (e) A health plan that provides coverage for prescription drugs shall allow enrollees to  
131 request an exception to the formulary. Under such an exception, a non-formulary drug could be  
132 deemed covered under the formulary if the prescribing physician determines that the formulary  
133 drug for treatment of the same condition either would not be as effective for the individual or  
134 would have adverse effects for the individual, or both.

135 (f) In the event an enrollee is denied an exception as provided by subsection (e) of this  
136 section, such denial shall be considered an adverse determination and will be subject to the  
137 health plan internal review process set forth in M.G.L. Ch. 176O.

138 (g) Nothing in this section shall be construed to require a health plan to:

139 (1) Provide coverage for any additional drugs not otherwise required by law;

140 (2) Implement specific utilization management techniques, such as prior authorization or  
141 step therapy; or

142 (3) Cease utilization of tiered cost-sharing structures, including those strategies used to  
143 incent use of preventive services, disease management, and low-cost treatment options.

144 Section 5. Sections 1 through 4 of this Act shall not apply to catastrophic plans as defined  
145 by M.G.L. Ch. 176J.

146 Section 6. This act shall apply to all policies, contracts and certificates of health insurance  
147 subject to section 47EE of chapter 175, section 8GG of chapter 176A, section 4GG of chapter

148 176B and section 4Y of chapter 176G of the General Laws delivered, issued or renewed on or  
149 after January 1, 2016.