

HOUSE No. 492

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 to reduce health care costs through improved medication management.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
<i>Jennifer E. Benson</i>	<i>37th Middlesex</i>
<i>Jose F. Tosado</i>	<i>9th Hampden</i>
<i>Jason M. Lewis</i>	<i>Fifth Middlesex</i>
<i>Danielle W. Gregoire</i>	<i>4th Middlesex</i>
<i>Kenneth I. Gordon</i>	<i>21st Middlesex</i>
<i>Hannah Kane</i>	<i>11th Worcester</i>
<i>Jeffrey N. Roy</i>	<i>10th Norfolk</i>
<i>David Paul Linsky</i>	<i>5th Middlesex</i>
<i>Paul McMurtry</i>	<i>11th Norfolk</i>
<i>Louis L. Kafka</i>	<i>8th Norfolk</i>
<i>Bud Williams</i>	<i>11th Hampden</i>
<i>Susan Williams Gifford</i>	<i>2nd Plymouth</i>
<i>Edward F. Coppinger</i>	<i>10th Suffolk</i>
<i>Michael S. Day</i>	<i>31st Middlesex</i>
<i>Steven Ultrino</i>	<i>33rd Middlesex</i>
<i>Denise Provost</i>	<i>27th Middlesex</i>
<i>Denise C. Garlick</i>	<i>13th Norfolk</i>
<i>James J. O'Day</i>	<i>14th Worcester</i>

HOUSE No. 492

By Ms. Benson of Lunenburg, a petition (accompanied by bill, House, No. 492) of Jennifer E. Benson and others relative to management of medications. Financial Services.

The Commonwealth of Massachusetts

**In the One Hundred and Ninetieth General Court
(2017-2018)**

An Act to reduce health care costs through improved medication management.

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 47BB the following section:-

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

5 “Clinical practice guidelines” means a systematically developed statement to assist
6 practitioner and patient decisions about appropriate healthcare for specific clinical circumstances
7 and conditions.

8 “Clinical review criteria” means the written screening procedures, decision abstracts,
9 clinical protocols and practice guidelines used by a carrier or utilization review organization to
10 determine the medical necessity and appropriateness of healthcare services.

11 “Step therapy protocol” means a protocol or program that establishes the specific
12 sequence in which prescription drugs for a specified medical condition and medically appropriate

13 for a particular patient and are covered as a pharmacy or medical benefit by a carrier, including
14 self-administered and physician-administered drugs.

15 “Step Therapy Override Exception Determination” means a determination as to whether
16 step therapy should apply in a particular situation, or whether the step therapy protocol should be
17 overridden in favor of immediate coverage of the patient’s and/or prescriber’s preferred drug.
18 This determination is based on a review of the patient’s and/or prescriber’s request for an
19 override, along with supporting rationale and documentation.

20 “Utilization review organization” means an entity that conducts utilization review, other
21 than a health carrier performing utilization review for its own health benefit plans.

22 (b) Any policy, contract, agreement, plan or certificate of insurance issued, delivered or
23 renewed within the commonwealth that provides coverage for prescription drugs and uses step-
24 therapy protocols shall have the following requirements and restrictions.

25 (1) Clinical review criteria used to establish step therapy protocols shall be based on
26 clinical practice guidelines that:

27 (A) That recommend drugs be taken in the specific sequence required by the step therapy
28 protocol.

29 (B) Are developed and endorsed by a multidisciplinary panel of experts that manages
30 conflicts of interest among the members of the writing and review groups by:

31 (i) Requiring members to disclose any potential conflict of interests with entities,
32 including insurers, health plans, and pharmaceutical manufacturers and recuse themselves of
33 voting if they have a conflict of interest.

34 (ii) Using a methodologist to work with writing groups to provide objectivity in data
35 analysis and ranking of evidence through the preparation of evidence tables and facilitating
36 consensus.

37 (iii) Offering opportunities for public review and comments.

38 (C) Are based on high quality studies, research, and medical practice.

39 (D) Are created by an explicit and transparent process that:

40 (i) Minimizes biases and conflicts of interest;

41 (ii) Explains the relationship between treatment options and outcomes;

42 (iii) Rates the quality of the evidence supporting recommendations; and

43 (iv) Considers relevant patient subgroups and preferences.

44 (E) Are continually updated through a review of new evidence, research and newly
45 developed treatments.

46 (2) In the absence of clinical guidelines that meet the requirements in section (1), peer
47 reviewed publications may be substituted.

48 (3) When establishing a step therapy protocol, a utilization review agent shall also take
49 into account the needs of atypical patient populations and diagnoses when establishing clinical
50 review criteria.

51 (4) This section shall not be construed to require insurers, health plans or the state to set
52 up a new entity to develop clinical review criteria used for step therapy protocols.

53 (c) When coverage of medications for the treatment of any medical condition are
54 restricted for use by a carrier or utilization review organization via a step therapy protocol, the
55 patient and prescribing practitioner shall have access to a clear readily accessible and convenient
56 process to request a Step Therapy Exception Determination. A carrier or utilization review
57 organization may use its existing medical exceptions process to satisfy this requirement. The
58 process shall be disclosed to the patient and health care providers, including documenting and
59 making easily accessible on the carriers' or utilization review organization's website.

60 (d) A step therapy override exception determination shall be expeditiously granted if:

61 (1) The required drug is contraindicated or will likely cause an adverse reaction by or
62 physical or mental harm to the patient;

63 (2) The required drug is expected to be ineffective based on the known relevant physical
64 or mental characteristics of the insured and the known characteristics of the drug regimen;

65 (3) The enrollee has tried the step therapy-required drug while under their current or a
66 previous health plan, or another drug in the same pharmacologic class or with the same
67 mechanism of action and such drugs were discontinued due to lack of efficacy or effectiveness,
68 diminished effect, or an adverse event;

69 (4) The patient is stable on a drug recommended by their health care provider for the
70 medical condition under consideration while on a current or previous health insurance or health
71 benefit plan;

72 (5) The step therapy-required drug is not in the best interest of the patient, based on
73 medical appropriateness.

74 (e) Upon the granting of a step therapy override exception determination, the carrier or
75 utilization review organization shall authorize coverage for the drug prescribed by the enrollee's
76 treating health care provider.

77 (f) The carrier or utilization review organization shall respond to step therapy override
78 exception request or an appeal within seventy two hours of receipt. In cases where exigent
79 circumstances exist a carrier or utilization review organization shall respond within twenty four
80 hours of receipts. Should a response by a carrier or utilization review organization not be
81 received within this time allotted the exception or appeal shall be deemed granted.

82 (g) This section shall not be construed to prevent:

83 (1) A carrier or utilization review organization from requiring an enrollee try an AB-
84 rated generic equivalent prior to providing reimbursement for the equivalent branded drug;

85 (2) A health care provider from prescribing a drug he or she determines is medically
86 appropriate.

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

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

91 "Clinical practice guidelines" means a systematically developed statement to assist
92 practitioner and patient decisions about appropriate healthcare for specific clinical circumstances
93 and conditions.

94 “Clinical review criteria” means the written screening procedures, decision abstracts,
95 clinical protocols and practice guidelines used by an insurer, health plan, or utilization review
96 organization to determine the medical necessity and appropriateness of healthcare services.

97 “Step therapy protocol” means a protocol or program that establishes the specific
98 sequence in which prescription drugs for a specified medical condition and medically appropriate
99 for a particular patient and are covered as a pharmacy or medical benefit by a carrier, including
100 self-administered and physician-administered drugs, .

101 “Step Therapy Override Exception Determination” means a determination as to whether
102 step therapy should apply in a particular situation, or whether the step therapy protocol should be
103 overridden in favor of immediate coverage of the patient’s and/or prescriber’s preferred drug.
104 This determination is based on a review of the patient’s and/or prescriber’s request for an
105 override, along with supporting rationale and documentation.

106 “Utilization review organization” means an entity that conducts utilization review, other
107 than a health carrier performing utilization review for its own health benefit plans.

108 (b) Any contract between a subscriber and the corporation under an individual or group
109 hospital service plan which is delivered, issued or renewed within the commonwealth that
110 provides coverage for prescription drugs and uses step-therapy protocols shall have the following
111 requirements and restrictions.

112 (1) Clinical review criteria used to establish step therapy protocols shall be based on
113 clinical practice guidelines that:

114 (A) That recommend drugs be taken in the specific sequence required by the step therapy
115 protocol.

116 (B) Are developed and endorsed by a multidisciplinary panel of experts that manages
117 conflicts of interest among the members of the writing and review groups by:

118 (i) Requiring members to disclose any potential conflict of interests with entities,
119 including insurers, health plans, and pharmaceutical manufacturers and reclude themselves of
120 voting if they have a conflict of interest.

121 (ii) Using a methodologist to work with writing groups to provide objectivity in data
122 analysis and ranking of evidence through the preparation of evidence tables and facilitating
123 consensus.

124 (iii) Offering opportunities for public review and comments.

125 (C) Are based on high quality studies, research, and medical practice.

126 (D) Are created by an explicit and transparent process that:

127 (i) Minimizes biases and conflicts of interest;

128 (ii) Explains the relationship between treatment options and outcomes;

129 (iii) Rates the quality of the evidence supporting recommendations; and

130 (iv) Considers relevant patient subgroups and preferences.

131 (E) Are continually updated through a review of new evidence, research and newly
132 developed treatments.

133 (2) In the absence of clinical guidelines that meet the requirements in section (1), peer
134 reviewed publications may be substituted.

135 (3) When establishing a step therapy protocol, a utilization review agent shall also take
136 into account the needs of atypical patient populations and diagnoses when establishing clinical
137 review criteria.

138 (4) This section shall not be construed to require insurers, health plans or the state to set
139 up a new entity to develop clinical review criteria used for step therapy protocols.

140 (c) When coverage of medications for the treatment of any medical condition are
141 restricted for use by a carrier or utilization review organization via a step therapy protocol, the
142 patient and prescribing practitioner shall have access to a clear readily accessible and convenient
143 process to request a Step Therapy Exception Determination. A carrier or utilization review
144 organization may use its existing medical exceptions process to satisfy this requirement. The
145 process shall be disclosed to the patient and health care providers, including documenting and
146 making easily accessible on the carriers' or utilization review organization's website.

147 (d) A step therapy override exception determination shall be expeditiously granted if:

148 (1) The required drug is contraindicated or will likely cause an adverse reaction by or
149 physical or mental harm to the patient;

150 (2) The required drug is expected to be ineffective based on the known relevant physical
151 or mental characteristics of the insured and the known characteristics of the drug regimen;

152 (3) The enrollee has tried the step therapy-required drug while under their current or a
153 previous health plan, or another drug in the same pharmacologic class or with the same

154 mechanism of action and such drugs were discontinued due to lack of efficacy or effectiveness,
155 diminished effect, or an adverse event;

156 (4) The patient is stable on a drug recommended by their health care provider for the
157 medical condition under consideration while on a current or previous health insurance or health
158 benefit plan;

159 (5) The step therapy-required drug is not in the best interest of the patient, based on
160 medical appropriateness.

161 (e) Upon the granting of a step therapy override exception determination, the carrier or
162 utilization review organization shall authorize coverage for the drug prescribed by the enrollee's
163 treating health care provider.

164 (f) The carrier or utilization review organization shall respond to step therapy override
165 exception request or an appeal within seventy two hours of receipt. In cases where exigent
166 circumstances exist a carrier or utilization review organization shall respond within twenty four
167 hours of receipts. Should a response by a carrier or utilization review organization not be
168 received within this time allotted the exception or appeal shall be deemed granted.

169 (g) This section shall not be construed to prevent:

170 (1) A carrier or utilization review organization from requiring an enrollee try an AB-
171 rated generic equivalent prior to providing reimbursement for the equivalent branded drug;

172 (2) A health care provider from prescribing a drug he or she determines is medically
173 appropriate.

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

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

178 “Clinical practice guidelines” means a systematically developed statement to assist
179 practitioner and patient decisions about appropriate healthcare for specific clinical circumstances
180 and conditions.

181 “Clinical review criteria” means the written screening procedures, decision abstracts,
182 clinical protocols and practice guidelines used by an insurer, health plan, or utilization review
183 organization to determine the medical necessity and appropriateness of healthcare services.

184 “Step therapy protocol” means a protocol or program that establishes the specific
185 sequence in which prescription drugs for a specified medical condition and medically appropriate
186 for a particular patient and are covered under a health benefit plan as a pharmacy or medical
187 benefit by a carrier, including self-administered and physician-administered drugs.

188 “Step Therapy Override Exception Determination” means a determination as to whether
189 step therapy should apply in a particular situation, or whether the step therapy protocol should be
190 overridden in favor of immediate coverage of the patient’s and/or prescriber’s preferred drug.
191 This determination is based on a review of the patient’s and/or prescriber’s request for an
192 override, along with supporting rationale and documentation.

193 “Utilization review organization” means an entity that conducts utilization review, other
194 than a health carrier performing utilization review for its own health benefit plans.

195 (b) Any subscription certificate under an individual or group medical service agreement
196 delivered, issued or renewed within the commonwealth that provides coverage for prescription
197 drugs and uses step-therapy protocols shall have the following requirements and restrictions.

198 (1) Clinical review criteria used to establish step therapy protocols shall be based on
199 clinical practice guidelines that:

200 (A) That recommend drugs be taken in the specific sequence required by the step therapy
201 protocol.

202 (B) Are developed and endorsed by a multidisciplinary panel of experts that manages
203 conflicts of interest among the members of the writing and review groups by:

204 (i) Requiring members to disclose any potential conflict of interests with entities,
205 including insurers, health plans, and pharmaceutical manufacturers and recuse themselves of
206 voting if they have a conflict of interest.

207 (ii) Using a methodologist to work with writing groups to provide objectivity in data
208 analysis and ranking of evidence through the preparation of evidence tables and facilitating
209 consensus.

210 (iii) Offering opportunities for public review and comments.

211 (C) Are based on high quality studies, research, and medical practice.

212 (D) Are created by an explicit and transparent process that:

213 (i) Minimizes biases and conflicts of interest;

214 (ii) Explains the relationship between treatment options and outcomes;

215 (iii) Rates the quality of the evidence supporting recommendations; and

216 (iv) Considers relevant patient subgroups and preferences.

217 (E) Are continually updated through a review of new evidence, research and newly
218 developed treatments.

219 (2) In the absence of clinical guidelines that meet the requirements in section (1), peer
220 reviewed publications may be substituted.

221 (3) When establishing a step therapy protocol, a utilization review agent shall also take
222 into account the needs of atypical patient populations and diagnoses when establishing clinical
223 review criteria.

224 (4) This section shall not be construed to require insurers, health plans or the state to set
225 up a new entity to develop clinical review criteria used for step therapy protocols.

226 (c) When coverage of medications for the treatment of any medical condition are
227 restricted for use by a carrier or utilization review organization via a step therapy protocol, the
228 patient and prescribing practitioner shall have access to a clear readily accessible and convenient
229 process to request a Step Therapy Exception Determination. A carrier or utilization review
230 organization may use its existing medical exceptions process to satisfy this requirement. The
231 process shall be disclosed to the patient and health care providers, including documenting and
232 making easily accessible on the carriers' or utilization review organization's website.

233 (d) A step therapy override exception determination shall be expeditiously granted if:

234 (1) The required drug is contraindicated or will likely cause an adverse reaction by or
235 physical or mental harm to the patient;

236 (2) The required drug is expected to be ineffective based on the known relevant physical
237 or mental characteristics of the insured and the known characteristics of the drug regimen;

238 (3) The enrollee has tried the step therapy-required drug while under their current or a
239 previous health plan, or another drug in the same pharmacologic class or with the same
240 mechanism of action and such drugs were discontinued due to lack of efficacy or effectiveness,
241 diminished effect, or an adverse event;

242 (4) The patient is stable on a drug recommended by their health care provider for the
243 medical condition under consideration while on a current or previous health insurance or health
244 benefit plan;

245 (5) The step therapy-required drug is not in the best interest of the patient, based on
246 medical appropriateness.

247 (e) Upon the granting of a step therapy override exception determination, the carrier or
248 utilization review organization shall authorize coverage for the drug prescribed by the enrollee's
249 treating health care provider.

250 (f) The carrier or utilization review organization shall respond to step therapy override
251 exception request or an appeal within seventy two hours of receipt. In cases where exigent
252 circumstances exist a carrier or utilization review organization shall respond within twenty four
253 hours of receipts. Should a response by a carrier or utilization review organization not be
254 received within this time allotted the exception or appeal shall be deemed granted.

255 (g) This section shall not be construed to prevent:

256 (1) A carrier or utilization review organization from requiring an enrollee try an AB-
257 rated generic equivalent prior to providing reimbursement for the equivalent branded drug;

258 (2) A health care provider from prescribing a drug he or she determines is medically
259 appropriate.

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

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

264 “Clinical practice guidelines” means a systematically developed statement to assist
265 practitioner and patient decisions about appropriate healthcare for specific clinical circumstances
266 and conditions.

267 “Clinical review criteria” means the written screening procedures, decision abstracts,
268 clinical protocols and practice guidelines used by an insurer, health plan, or utilization review
269 organization to determine the medical necessity and appropriateness of healthcare services.

270 “Step therapy protocol” means a protocol or program that establishes the specific
271 sequence in which prescription drugs for a specified medical condition and medically appropriate
272 for a particular patient and are covered under a health benefit plan as a pharmacy or medical
273 benefit by a carrier, including self-administered and physician-administered drugs, .

274 “Step Therapy Override Exception Determination” means a determination as to whether
275 step therapy should apply in a particular situation, or whether the step therapy protocol should be
276 overridden in favor of immediate coverage of the patient’s and/or prescriber’s preferred drug.

277 This determination is based on a review of the patient’s and/or prescriber’s request for an
278 override, along with supporting rationale and documentation.

279 “Utilization review organization” means an entity that conducts utilization review, other
280 than a health carrier performing utilization review for its own health benefit plans.

281 (b) Any individual or group health maintenance that provides coverage for prescription
282 drugs and uses step-therapy protocols shall have the following requirements and restrictions.

283 (1) Clinical review criteria used to establish step therapy protocols shall be based on
284 clinical practice guidelines that:

285 (A) That recommend drugs be taken in the specific sequence required by the step therapy
286 protocol.

287 (B) Are developed and endorsed by a multidisciplinary panel of experts that manages
288 conflicts of interest among the members of the writing and review groups by:

289 (i) Requiring members to disclose any potential conflict of interests with entities,
290 including insurers, health plans, and pharmaceutical manufacturers and recuse themselves of
291 voting if they have a conflict of interest.

292 (ii) Using a methodologist to work with writing groups to provide objectivity in data
293 analysis and ranking of evidence through the preparation of evidence tables and facilitating
294 consensus.

295 (iii) Offering opportunities for public review and comments.

296 (C) Are based on high quality studies, research, and medical practice.

297 (D) Are created by an explicit and transparent process that:

298 (i) Minimizes biases and conflicts of interest;

299 (ii) Explains the relationship between treatment options and outcomes;

300 (iii) Rates the quality of the evidence supporting recommendations; and

301 (iv) Considers relevant patient subgroups and preferences.

302 (E) Are continually updated through a review of new evidence, research and newly
303 developed treatments.

304 (2) In the absence of clinical guidelines that meet the requirements in section (1), peer
305 reviewed publications may be substituted.

306 (3) When establishing a step therapy protocol, a utilization review agent shall also take
307 into account the needs of atypical patient populations and diagnoses when establishing clinical
308 review criteria.

309 (4) This section shall not be construed to require insurers, health plans or the state to set
310 up a new entity to develop clinical review criteria used for step therapy protocols.

311 (c) When coverage of medications for the treatment of any medical condition are
312 restricted for use by a carrier or utilization review organization via a step therapy protocol, the
313 patient and prescribing practitioner shall have access to a clear readily accessible and convenient
314 process to request a Step Therapy Exception Determination. A carrier or utilization review
315 organization may use its existing medical exceptions process to satisfy this requirement. The

316 process shall be disclosed to the patient and health care providers, including documenting and
317 making easily accessible on the carriers' or utilization review organization's website.

318 (d) A step therapy override exception determination shall be expeditiously granted if:

319 (1) The required drug is contraindicated or will likely cause an adverse reaction by or
320 physical or mental harm to the patient;

321 (2) The required drug is expected to be ineffective based on the known relevant physical
322 or mental characteristics of the insured and the known characteristics of the drug regimen;

323 (3) The enrollee has tried the step therapy-required drug while under their current or a
324 previous health plan, or another drug in the same pharmacologic class or with the same
325 mechanism of action and such drugs were discontinued due to lack of efficacy or effectiveness,
326 diminished effect, or an adverse event;

327 (4) The patient is stable on a drug recommended by their health care provider for the
328 medical condition under consideration while on a current or previous health insurance or health
329 benefit plan;

330 (5) The step therapy-required drug is not in the best interest of the patient, based on
331 medical appropriateness.

332 (e) Upon the granting of a step therapy override exception determination, the carrier or
333 utilization review organization shall authorize coverage for the drug prescribed by the enrollee's
334 treating health care provider.

335 (f) The carrier or utilization review organization shall respond to step therapy override
336 exception request or an appeal within seventy two hours of receipt. In cases where exigent

337 circumstances exist a carrier or utilization review organization shall respond within twenty four
338 hours of receipts. Should a response by a carrier or utilization review organization not be
339 received within this time allotted the exception or appeal shall be deemed granted.

340 (g) This section shall not be construed to prevent:

341 (1) A carrier or utilization review organization from requiring an enrollee try an AB-
342 rated generic equivalent prior to providing reimbursement for the equivalent branded drug;

343 (2) A health care provider from prescribing a drug he or she determines is medically
344 appropriate.

345 SECTION 5. Sections 1 to 5, inclusive, shall apply to all policies, contracts and
346 certificates of health insurance subject to section 17K of chapter 32A, section 47CC of chapter
347 175, section 8FF of chapter 176A, section 4FF of chapter 176B and section 4X of chapter 176G
348 of the General Laws which are delivered, issued or renewed on or after January 1, 20XX.