

**SENATE . . . . . No. 616**

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**The Commonwealth of Massachusetts**

PRESENTED BY:

*Julian Cyr*

*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:

*Julian Cyr*

DISTRICT/ADDRESS:

*Cape and Islands*

**SENATE . . . . . No. 616**

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By Mr. Cyr, a petition (accompanied by bill, Senate, No. 616) of Julian Cyr for legislation relative to patient cost, benefit and coverage information, choice, and price transparency. Financial Services.

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[SIMILAR MATTER FILED IN PREVIOUS SESSION  
SEE SENATE, NO. 650 OF 2021-2022.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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