

CHAPTER 13
HB 1280-FN - FINAL VERSION

11Mar2020... 0105h
06/16/2020 1470s
30Jun2020... 1631EBA

2020 SESSION

20-2032
01/03

HOUSE BILL ***1280-FN***

AN ACT relative to copayments for insulin, establishing a wholesale prescription drug importation program, establishing a New Hampshire prescription drug affordability board, establishing the prescription drug competitive marketplace, relative to the pricing of generic prescription drugs, relative to prior authorization for prescription drug coverage, and requiring insurance coverage for epinephrine auto-injectors.

SPONSORS: Rep. Muscatel, Graf. 12; Rep. Levesque, Straf. 4; Rep. Stevens, Hills. 34; Rep. Grassie, Straf. 11; Rep. Merchant, Sull. 4; Rep. Buchanan, Merr. 15; Rep. Riel, Hills. 6; Rep. St. John, Hills. 27; Rep. Marsh, Carr. 8; Rep. Ebel, Merr. 5; Sen. Ward, Dist 8; Sen. Feltes, Dist 15; Sen. Rosenwald, Dist 13; Sen. Hennessey, Dist 5

COMMITTEE: Commerce and Consumer Affairs

AMENDED ANALYSIS

This bill:

I. Requires insurers to cap the total amount paid for insulin for covered persons.

II. Establishes a wholesale importation program for prescription drugs from Canada by or on behalf of the state. This bill requires the department of health and human services to design the program and obtain federal approval for the program.

III. Establishes a prescription drug affordability board to determine annual public payor spending targets for prescription drugs, develop and implement policies and procedures for the collection of prescription drug price data, implement a register of drug manufacturers for drug pricing data, and establish funding for the board by reasonable user fees and assessments.

IV. Clarifies the pricing of generic prescription drugs under the law governing consumer protection.

V. Clarifies the procedure for prior authorization for prescription drugs on the formulary under the managed care law.

VI. Requires insurance coverage for epinephrine autoinjectors.

VII. Establishes the prescription drug competitive marketplace.

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Explanation: Matter added to current law appears in ***bold italics***.
Matter removed from current law appears ~~[in brackets and struckthrough.]~~
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

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STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty

AN ACT relative to copayments for insulin, establishing a wholesale prescription drug importation program, establishing a New Hampshire prescription drug affordability board, establishing the prescription drug competitive marketplace, relative to the pricing of generic prescription drugs, relative to prior authorization for prescription drug coverage, and requiring insurance coverage for epinephrine auto-injectors.

Be it Enacted by the Senate and House of Representatives in General Court convened:

13:1 Accident and Health Insurance; Coverage for Diabetes Services and Supplies; Individual.
Amend RSA 415:6-e to read as follows:

415:6-e Coverage for Diabetes Services and Supplies. Each insurer that issues or renews any individual policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance, who are residents of this state, coverage for medically appropriate and necessary outpatient self-management training and educational services, pursuant to a written order of a primary care physician or practitioner, including but not limited to medical nutrition therapy for the treatment of diabetes, provided by a certified, registered, or licensed health care professional with expertise in diabetes, subject to the terms and conditions of the policy. Each insurer that issues or renews any individual policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses which provides a prescription rider shall cover medically appropriate or necessary insulin, oral agents, and equipment used to treat diabetes subject to the terms and conditions of the policy. ***Each insurer that provides coverage for prescription insulin drugs shall cap the total amount that a covered person is required to pay for each covered insulin drug prescription at an amount not to exceed \$30 for each 30-day supply of each insulin prescription. The maximum \$30 copayment for each 30-day supply of each covered insulin drug prescription shall apply when an original prescription is dispensed as well as when refills of the prescription are dispensed, including early refills. Coverage for prescription insulin drugs shall not be subject to any deductible.*** Each insurer that issues or renews any individual policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses which provides for durable medical equipment coverage shall provide coverage for medically appropriate or necessary equipment used to treat diabetes subject to the terms and conditions of the policy.

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13:2 Accident and Health Insurance; Coverage for Diabetes Services and Supplies; Group. Amend RSA 415:18-f to read as follows:

415:18-f Coverage for Diabetes Services and Supplies. Each insurer that issues or renews any policy, plan, or contract of group accident or health insurance providing benefits for medical or hospital expenses, shall provide each group, or to the portion of each group comprised of certificate holders of such insurance who are residents of this state, coverage for medically appropriate and necessary outpatient self-management training and educational services, pursuant to a written order of a primary care physician or practitioner, including but not limited to medical nutrition therapy for the treatment of diabetes, provided by a certified, registered, or licensed health care professional with expertise in diabetes, subject to the terms and conditions of the policy. Each insurer that issues or renews any group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses which provides a prescription rider shall cover medically appropriate or necessary insulin, oral agents, and equipment used to treat diabetes subject to the terms and conditions of the policy. ***Each insurer that provides coverage for prescription insulin drugs shall cap the total amount that a covered person is required to pay for each covered insulin drug prescription at an amount not to exceed \$30 for each 30-day supply of each insulin prescription. The maximum \$30 copayment for each 30-day supply of each covered insulin drug prescription shall apply when an original prescription is dispensed as well as when refills of the prescription are dispensed, including early refills. Coverage for prescription insulin drugs shall not be subject to any deductible.*** Each insurer that issues or renews any group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses which provides for durable medical equipment coverage shall provide coverage for medically appropriate or necessary equipment used to treat diabetes subject to the terms and conditions of the policy.

13:3 Health Service Corporations; Coverage for Diabetes Services and Supplies. Amend RSA 420-A:17-a to read as follows:

420-A:17-a Coverage for Diabetes Services and Supplies. Every health service corporation and every similar corporation licensed under the laws of another state that issues or renews any policy, plan, or contract of individual or group accident or health insurance providing benefits for medical or hospital expenses, shall provide to each individual or group, or to the portion of each group comprised of certificate holders of such insurance who are residents of this state, coverage for the medically appropriate and necessary outpatient self-management training and educational services, pursuant to a written order of a primary care physician or practitioner, including but not limited to medical nutrition therapy for the treatment of diabetes, provided by a certified, registered, or licensed health care professional with expertise in diabetes, subject to the terms and conditions of the policy. Each health service corporation that issues or renews any individual or group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses

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which provides a prescription rider shall cover medically appropriate or necessary insulin, oral agents, and equipment used to treat diabetes subject to the terms and conditions of the policy. ***Each health service corporation that provides coverage for prescription insulin drugs shall cap the total amount that a covered person is required to pay for each covered insulin drug prescription at an amount not to exceed \$30 for each 30-day supply of each insulin prescription. The maximum \$30 copayment for each 30-day supply of each covered insulin drug prescription shall apply when an original prescription is dispensed as well as when refills of the prescription are dispensed, including early refills. Coverage for prescription insulin drugs shall not be subject to any deductible.*** Each health service corporation that issues or renews any individual or group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses which provides for durable medical equipment coverage shall provide coverage for medically appropriate or necessary equipment used to treat diabetes subject to the terms and conditions of the policy.

13:4 Health Maintenance Organizations; Coverage for Diabetes Services and Supplies. Amend RSA 420-B:8-k to read as follows:

420-B:8-k Coverage for Diabetes Services and Supplies. Every health maintenance organization and every similar corporation licensed under the laws of another state that issues or renews any policy, plan, or contract of individual or group health insurance providing benefits for medical or hospital expenses, shall provide to each individual or group, or to the portion of each group comprised of certificate holders of such insurance who are residents of this state, coverage for the medically appropriate and necessary outpatient self-management training and educational services, pursuant to a written order of a primary care physician or practitioner, including but not limited to medical nutrition therapy for the treatment of diabetes, provided by a certified, registered, or licensed health care professional with expertise in diabetes, subject to the terms and conditions of the policy. Each health maintenance organization that issues or renews any individual or group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses which provides a prescription rider shall cover medically appropriate or necessary insulin, oral agents, and equipment used to treat diabetes subject to the terms and conditions of the policy. ***Each health maintenance organization that provides coverage for prescription insulin drugs shall cap the total amount that a covered person is required to pay for each covered insulin drug prescription at an amount not to exceed \$30 for each 30-day supply of each insulin prescription. The maximum \$30 copayment for each 30-day supply of each covered insulin drug prescription shall apply when an original prescription is dispensed as well as when refills of the prescription are dispensed, including early refills. Coverage for prescription insulin drugs shall not be subject to any deductible.*** Each health maintenance organization that issues or renews any individual or group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses which provides for durable

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medical equipment coverage shall provide coverage for medically appropriate or necessary equipment used to treat diabetes subject to the terms and conditions of the policy.

13:5 New Chapter; Prescription Drug Affordability Board. Amend RSA by inserting after chapter 126-AA the following new chapter:

CHAPTER 126-BB

NEW HAMPSHIRE PRESCRIPTION DRUG AFFORDABILITY BOARD

126-BB:1 Definitions. In this chapter:

- I. "Board" means the New Hampshire prescription drug affordability board.
- II. "Brand-name drug" means a prescription drug marketed under a proprietary name or registered trademark name, including a biological product.
- III. "Generic drug" means a prescription drug, whether identified by its chemical, proprietary, or nonproprietary name, that is not a brand-name drug and is therapeutically equivalent to a brand-name drug in dosage, safety, strength, method of consumption, quality, performance, and intended use. "Generic drug" includes a biosimilar product.
- IV. "Manufacturer" means a manufacturer of prescription drugs that are distributed in the state. A manufacturer excludes a packager, repackager, labeler, and relabeler.
- V. "Pricing unit" means the smallest dispensable amount of a prescription drug that could be dispensed.
- VI. "Public payor" means any division of state, county, or municipal government that administers a health plan for its employees or an association of state, county, or municipal employers that administers a health plan for its employees.
- VII. "Wholesale acquisition cost" means a manufacturer's listed price for sale to a wholesale drug distributor or other entity that purchases a prescription drug directly from the manufacturer, not including any price concessions.

126-BB:2 New Hampshire Prescription Drug Affordability Board Established. There is established the New Hampshire prescription drug affordability board to carry out the purposes of this chapter.

I. The board shall consist of 5 members with expertise in health care economics or clinical medicine, who shall not be, or be directly related to, anyone affiliated with, employed by, or representing the interests of a public payor, pharmaceutical or pharmacy company, pharmacy benefits management company, or health insurance provider and who have completed a conflict of interest statement. They shall be appointed as follows:

(a) Two members by the president of the senate. The president of the senate shall also appoint one alternate board member who will participate in deliberations of the board in the event a member appointed by the president of the senate elects to be recused as provided in RSA 126-BB:3.

(b) Two members by the speaker of the house of representatives. The speaker of the house of representatives shall also appoint one alternate board member who will participate in

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deliberations of the board in the event a member appointed by the speaker of the house of representatives elects to be recused as provided in RSA 126-BB:3.

(c) One member by the governor. The governor shall also appoint one alternate board member who shall participate in deliberations of the board in the event the member appointed by the governor elects to be recused as provided in RSA 126-BB:3.

II. Members shall be appointed to 5-year terms. Of the initial appointees, the member appointed by the governor shall serve an initial term of 5 years, one member appointed by the president of the senate and one member appointed by the speaker of the house of representatives shall serve an initial term of 4 years and one member appointed by the president of the senate and one member appointed by the speaker of the house of representatives shall serve an initial term of 3 years.

III. A majority of board members shall constitute a quorum.

IV. The chair of the board shall be elected by an affirmative vote of at least 4 of the 5 members of the board.

V. Beginning no later than March 1, 2021, the board shall meet in public session at least every 12 weeks to review prescription drug information and to make recommendations pursuant to RSA 126-BB:5. The first meeting shall be called by the first-named appointee of the senate president.

(a) Each public meeting shall be announced 2 weeks in advance, and materials for the meeting shall be made public at least one week in advance.

(b) Each public meeting shall provide opportunity for comment from the public in attendance at the meeting, and the board shall provide the opportunity for the public to submit written comments on pending decisions.

(c) The board may allow expert testimony at public meetings and any meeting conducted in executive session as permitted by subparagraph (d).

(d) Notwithstanding requirements of RSA 91-A, the board may meet in executive session, except that any decision of the board shall be made in public.

VI. The board shall be administratively attached to the department of health and human services. The board may employ an executive director who shall be a classified employee.

126-BB:3 Conflicts of Interest. The following provisions govern any conflict of interest for a member of the board, a member of the advisory council established in RSA 126-BB:4 or any staff member or contractor of the board.

I. When appointing a member of the board or the advisory council, the appointing authority shall consider any conflict of interest disclosed by the prospective member. A member shall elect to be recused from any board activity in the case in which the member or an immediate family member of the member has a conflict of interest. For the purposes of this paragraph, "conflict of interest" means an association, including a financial or personal association, that has the potential to bias or

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have the appearance of biasing an individual's decisions in matters related to the board or the conduct of the board's activities.

II. A board member or staff or contractor of the board with a conflict of interest shall elect to be recused. For purposes of this paragraph, "conflict of interest" means any instance in which a member of the board or an immediate family member of the member has received or could receive either of the following:

(a) A direct financial benefit of any amount deriving from the results or findings of a study or determination by or for the board; or

(b) A financial benefit from individuals or companies that own or manufacture prescription drugs, services, or items to be studied by the board that in the aggregate exceeds \$5,000 per year. For purposes of this subparagraph, "financial benefit" includes honoraria, fees, stock, or other financial benefit and the current value of the member's or immediate family member's already existing stock holdings, in addition to any direct financial benefit deriving from the results or findings conducted under this section.

(c) A conflict of interest shall be disclosed in the following manner:

(1) By the board in the employment of board senior staff.

(2) By the governor, president of the senate, or speaker of the house of representatives when appointing members to the board and advisory council.

(3) By the board in describing any recusals as part of any final decision relating to a prescription drug.

(4) By the 5th day after a conflict is identified or, if a public meeting of the board will occur within that 5-day period, in advance of the public meeting.

(d) Conflicts of interest shall be publicly posted on the website of the board. The information disclosed shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent that the individual elects to be recused from participation in any activity with respect to which the potential conflict exists.

(e) The board, the advisory council, a member of the board or staff, or a contractor of the board may not accept gifts, bequests, or donations of services or property that suggest a conflict of interest or have the appearance of creating bias in the work of the board or advisory council.

(f) A member of the advisory council who accepts a gift, bequest, or donation of services or property that suggests a conflict of interest or has the appearance of creating bias in the work of the advisory council shall disclose the gift, bequest, or donation publicly.

126-BB:4 Advisory Council. A 12-member advisory council is established to advise the board on establishing annual spending targets pursuant to RSA 126-BB:5, I and determining methods for meeting those spending targets pursuant to RSA 126-BB:5, III. The advisory council shall consist of the following members:

I. The governor, or designee.

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- II. The commissioner of the department of administrative services, or designee.
- III. The commissioner of the department of corrections, or designee.
- IV. The commissioner of department of health and human services, or designee.
- V. The attorney general, or designee.
- VI. The director of the division of risk and benefits, department of administrative services, or designee.
- VII. The president of the New Hampshire State Employees Association, or designee.
- VIII. The president of the New Hampshire Education Association, or designee.
- IX. The executive director of the New Hampshire Municipal Association or designee.
- X. The chancellor of the university system of New Hampshire, or designee.
- XI. The chancellor of the New Hampshire community college system, or designee.
- XII. A representative of consumer interests, appointed by the governor, who shall serve a 3-year term.

126-BB:5 Powers and Duties of the Board. The board has the following powers and duties:

I.(a) Beginning with the year 2022 and in consultation with the advisory council, the board shall identify strategies that optimize spending by public payors for pharmaceutical products while reasonably ensuring subscriber access to needed pharmaceutical products. To achieve this goal, the board shall determine annual spending targets for prescription drugs purchased by public payors based upon a 10-year rolling average of the medical care services component of the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index, medical care services index, plus a reasonable percentage for inflation and minus a spending target for pharmacy savings as determined by the board.

(b) The board shall determine spending targets on specific prescription drugs that may cause affordability challenges to enrollees in a public payor health plan. Such targets shall consider any medical cost offsets achieved by utilization of the drug.

(c) The board shall determine which public payors are likely to exceed the spending targets determined under subparagraph (a).

II. The board may consider the following data to accomplish its duties under this section:

(a) A public payor's prescription drug spending data, which the 3rd-party administrator or insurer for the public payor's health plan shall provide to the board on behalf of the public payor upon request notwithstanding any provision of law to the contrary, including:

(1) Expenditures and utilization data for prescription drugs for each plan offered by a public payor.

(2) The formulary for each plan offered by a public payor and prescription drugs common to each formulary.

(3) Pharmacy benefit management services and other administrative expenses of the prescription drug benefit for each plan offered by a public payor.

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(4) Enrollee cost sharing for each plan offered by a public payor.

(5) Aggregate net spending on the prescription drug benefit.

(b) Data compiled by the department of health and human services. Prescription drug spending data provided to the board under this subparagraph is confidential to the same extent it is confidential while in the custody of the entity that provided the data to the board.

III. Based upon the prescription drug spending data received under paragraph II, the board, in consultation with a representative of each public payor shall determine methods for the public payor to meet the spending targets established under paragraph I. While continuing to ensure adequate access by subscribers to needed prescribed pharmaceutical products, the board shall determine whether the following methods reduce costs to individuals purchasing prescription drugs through a public payor and allow public payors to meet the spending targets established under paragraph I:

(a) Negotiating specific rebate amounts on the prescription drugs that contribute most to spending that exceeds the spending targets.

(b) Changing a formulary when sufficient rebates cannot be secured under subparagraph (a).

(c) Establishing a common prescription drug formulary for all public payors.

(d) Prohibiting health insurance carriers in the state administering benefits for a public payor from offering on their formularies prescription drugs when the method described in subparagraph (b) is implemented.

(e) Purchasing prescription drugs in bulk or through a single purchasing agreement for use among public payors.

(f) Collaborating with other states and state prescription drug purchasing consortia to purchase prescription drugs in bulk or to jointly negotiate rebates.

(g) Allowing health insurance carriers providing coverage to small businesses and individuals in the state to participate in the public payor prescription drug benefit for a fee.

(h) Procuring common expert services for public payor, including but not limited to pharmacy benefit management services and actuarial services.

IV. By November 1, 2020 and annually thereafter, the board shall report its recommendations, including prescription drug spending targets, their strategies for optimization of affordability of prescription drugs for the state and all of its residents, the progress of implementing those recommendations, as well as the annual net spending by public payors on prescription pharmaceutical products as a measure of the efficacy of implementation of those recommendations to date, to the standing committees of the general court with jurisdiction over health coverage and insurance matters and to the governor. This report shall also contain the following information about prescription drugs, both brand name and generic:

(a) The 25 most frequently prescribed drugs in the state;

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(b) The 25 costliest drugs as determined by the total amount spent on those drugs in the state; and

(c) The 25 drugs with the highest year-over-year cost increases as determined by the total amount spent on those drugs in the state.

V. The board may apply for and receive funds, grants, or contracts from public and private sources.

126-BB:6 Rulemaking. The board shall adopt rules under RSA 541-A for the following:

I. Procedures for drug price transparency as required under RSA 126-BB:7.

II. The adoption of all fees under RSA 126-BB:8.

III. Proceedings for assessing civil fines under RSA 126-BB:10.

IV. Any other matter required to implement this chapter.

126-BB:7 Drug Price Transparency; Non-disclosure Requirements.

I. The board shall develop and implement policies and procedures for its collection, processing, storage, and analysis of clinical, financial, quality restructuring and prescription drug price data for the following purposes:

(a) To use, build, and improve upon and coordinate existing data sources and measurement efforts through the integration of data systems and standardization of concepts.

(b) To coordinate the development of a linked public and private sector information system.

(c) To emphasize data that is useful, relevant, and not duplicative of existing data.

(d) To minimize the burden on those providing data.

(e) To preserve the reliability, accuracy, and integrity of collected data.

II. The board shall adopt rules to ensure that:

(a) Payors, providers, prescription drug manufacturers, wholesale drug distributors, and pharmacy benefits managers file data as required by RSA 126-BB:9.

(b) Users that obtain health data and information from the board safeguard the identification of patients and health care practitioners.

(c) Payors, providers, prescription drug manufacturers, wholesale drug distributors, and pharmacy benefits managers pay all assessments as required by RSA 126-BB:8.

(d)(1) Only the board and employees assigned to the board may access the information received pursuant to this chapter and only for purpose of effectuating the powers and duties granted the board by this chapter. The board shall limit access to any information that it receives pursuant to this chapter to the smallest number of employees and other personnel possible; and all such individuals shall, as a condition of employment, be required to execute non-disclosure agreements under which they are restricted from disclosing any information they may receive in connection with this chapter during their employment term and in perpetuity post-employment.

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(2) If the board, its members, employees, or personnel willfully shares or discloses for unauthorized purposes information that is trade secret information, confidential, commercial or proprietary information, or information designated as “confidential” by the owner of the information, the board or the individual who made the unauthorized disclosure may be subject to any penalties available under federal and state laws, including trade secret misappropriation laws, to the extent permitted by law.

126-BB:8 Funding; Assessment of Fees.

I. The expenses and cost of operation of the board shall be funded by reasonable user fees and assessments determined in rules adopted by the board.

(a) Fees may be charged for the reasonable costs of duplicating, mailing, publishing, and supplies.

(b) Reasonable user fees shall be charged on a sliding scale for the right to access and use the health data and information available from the board. Fees may be charged for services provided to the department on a contractual basis. Fees may be reduced or waived for users that demonstrate a plan to use the data or information in research of general value to the public health or inability to pay the scheduled fees, as provided by rules adopted by the board.

(c) Annual assessments of not less than \$100 assessed against the following entities:

(1) Health insurance carriers and health maintenance organizations on the basis of the total annual health care premium.

(2) Third-party administrators.

(3) Health carriers that provide only administrative services for a plan sponsor.

(4) Pharmacy benefits managers that process and pay claims on the basis of claims processed or paid for each plan sponsor.

(d) Health care policies issued for specified disease, accident, injury, hospital indemnity, disability, long-term care or other limited benefit health insurance policies are not subject to assessment under subparagraph (c). For purposes of this paragraph, policies issued for dental services are not considered to be limited benefit health insurance policies.

(e) Annual assessments of not less than \$500 assessed by the board against prescription drug manufacturers, wholesale drug distributors, and pharmacy benefits managers.

II. The aggregate level of annual assessments under subparagraphs (c) and (e) shall be an amount sufficient to meet the board's expenditures authorized. The board may waive assessments otherwise due under subparagraphs (c) and (e) when a waiver is determined to be in the interests of the board and the parties to be assessed.

126-BB:9 Drug Price Notifications and Disclosures; Confidentiality; Registration.

I. No later than January 30, 2021 and annually thereafter, a manufacturer shall notify the board when the manufacturer has during the prior calendar year:

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(a) Increased the wholesale acquisition cost of a brand-name drug by more than 20 percent per pricing unit;

(b) Increased the wholesale acquisition cost of a generic drug that costs at least \$10 per pricing unit by more than 20 percent per pricing unit; or

(c) Introduced a new drug for distribution in this state when the wholesale acquisition cost is greater than the amount that would cause the drug to be considered a specialty drug under the Medicare Part D program. For the purposes of this section, "Medicare Part D" means prescription drug benefit in accordance with the requirements of the federal Medicare Prescription Drug Improvement and Modernization Act of 2003.

II.(a) To develop the report under paragraph VIII, the board shall first assess public information that is readily available. To the extent there is no public information or not enough public information readily available to the board to produce its report, the board may request information from:

(1) The manufacturer that provided notice to the board pursuant to paragraph I;

(2) A pharmacy benefit manager or health insurance carrier providing services involving the drug that is the subject of the notification provided pursuant to paragraph I.

(b) Once the board requests information of a manufacturer, pharmacy benefit manager, or health insurance carrier, the entity shall have 60 days to produce the requested information regarding the prescription drug that is the subject of the request. If, after a complete review of all information and data available to the board or as received from the entities, the board makes a determination that additional data is required for a particular prescription drug to produce the report under paragraph VIII, the board may request that additional information from wholesale drug distributors that distribute the prescription drug that is the subject of the report. Once the board requests information of a wholesale drug distributor, it shall have 60 days to produce information regarding the prescription drug that is the subject of the request.

III.(a) Upon receipt of a request from the board relating to a specific prescription drug for which notice was provided pursuant to paragraphs I and II, a manufacturer shall provide to the board, in a form and manner specified by the board, (i) a written, narrative description, suitable for public release, of all factors that caused the increase in the wholesale acquisition cost of the listed outpatient prescription drug, and (ii) aggregate, company-level research and development costs and such other capital expenditures that the board, in its discretion, deems relevant for the most recent year for which final audited data are available.

(b) The data that a pharmaceutical manufacturer submits to the board under this section may be limited to the information and data that the pharmaceutical manufacturer includes in such pharmaceutical manufacturer's annual consolidated report on Securities and Exchange Commission Form 10-K, or any other public disclosure.

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(c) The board shall establish a standardized form for reporting information and data pursuant to this section after consulting with pharmaceutical manufacturers. The form shall be designed to minimize the administrative burden and cost of reporting on the office and pharmaceutical manufacturers.

(d) Upon a request from the board relating to a specific prescription drug for which notice was provided pursuant to paragraphs I and II, a pharmacy benefit manager or wholesaler shall provide:

(1) The dollar amount of all rebates or fees concerning the drug collected from the manufacturer that were covered by such health carriers during such calendar year; and

(2) The dollar amount of all rebates and fees, excluding any portion of the rebates or fees received by health carriers, concerning the drug collected from the manufacturer.

(3) Fees referenced in subparagraphs (1) and (2) shall exclude those that are determined to be bona fide service fees as defined by the United States Department of Health and Human Services and codified in 42 C.F.R. 414.803.

(e) The board shall establish a standardized form for reporting information pursuant to subparagraph (d) after consultation with pharmacy benefits managers and wholesalers. The form shall be designed to minimize the administrative burden and cost of reporting on pharmacy benefits managers and wholesalers.

IV. Information provided to the board as required by this section by a manufacturer, wholesale drug distributor, or pharmacy benefits manager that has not been publicly reported is confidential and not a public record under RSA 91-A, except that the board may share information:

(a) With the insurance department, to the extent necessary for the department to enforce insurance laws, as long as any information shared is kept confidential; and

(b) As long as it is not released in a manner that represents a breach of confidential information provided by a manufacturer, wholesale drug distributor, or pharmacy benefits manager.

V. Beginning January 1, 2021, a manufacturer, pharmacy benefits manager, and wholesale drug distributor subject to this section shall register annually with the board in a manner prescribed by the board.

VI. A manufacturer, wholesale drug distributor, or pharmacy benefits manager that submits a notification or report to the board pursuant to this section shall submit with the notification or report a signed written certification of the notification's or report's accuracy. Any confidential or proprietary information contained within such notification or report shall be clearly identified as such. Any breach of confidential information not so identified shall not be subject to RSA 126-BB:7, II(d).

VII.(a) The board may audit the data submitted by a manufacturer, wholesale drug distributor, or pharmacy benefits manager pursuant to this section. The audits shall only be conducted when the state has reasonable cause to believe information received is inaccurate. The

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board shall notify the entity to be audited with sufficient notice before conducting the audit. The costs of the audit shall be paid for by the manufacturer, wholesale drug distributor, or pharmacy benefits manager.

(b) The board may require a manufacturer, wholesale drug distributor, or pharmacy benefits manager subject to this section to develop a corrective action plan to correct any deficiencies the board finds with the manufacturer's, wholesale drug distributor's, or pharmacy benefits manager's compliance with this section.

VIII. Beginning November 1, 2021 and annually thereafter, the board shall produce and post on its publicly accessible website an annual report, including information developed from the notifications and disclosures received pursuant to this section on trends in the cost of prescription drugs, analysis of manufacturer prices and price increases, the major components of prescription drug pricing along the supply chain and the impacts on insurance premiums and cost sharing, and any other information the board determines is relevant to providing greater consumer awareness of the factors contributing to the cost of prescription drugs in the state. The report may not disclose information attributable to any particular manufacturer, wholesale drug distributor, or pharmacy benefits manager subject to this section and may not make public any information that is confidential. The board shall submit the report required by this section to the standing committees of the general court with jurisdiction over health data reporting and prescription drug matters and the governor.

126-BB:10 Civil Penalties. When a person or entity that is a health care facility payor, prescription drug manufacturer, wholesale drug distributor, or pharmacy benefits manager violates any requirement of this chapter, that person or entity commits a civil violation for which a fine of not more than \$1,000 per day may be imposed. A fine imposed under this paragraph may not exceed \$25,000 for any one occurrence.

13:6 New Chapter; Wholesale Prescription Drug Importation Program. Amend RSA by inserting after chapter 126-BB the following new chapter:

CHAPTER 126-CC

WHOLESALE PRESCRIPTION DRUG IMPORTATION PROGRAM

126-CC:1 Definitions. In this chapter:

- I. "Commissioner" means the commissioner of the department of health and human services.
- II. "Department" means the department of health and human services.
- III. "Program" means the wholesale prescription drug importation program.

126-CC:2 Design of Program: Rulemaking.

I. There is hereby established the wholesale prescription drug importation program, referred to in this chapter as the "program," to provide for the wholesale importation of prescription drugs from Canada by or on behalf of the state.

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II. The department, in consultation with appropriate federal and other state agencies and interested parties, shall design the program to comply with the applicable requirements of 21 U.S.C. section 384, including requirements regarding safety and cost savings. The program design shall:

(a) Designate a state agency to become a licensed drug wholesaler or to contract with a licensed drug wholesaler in order to seek federal certification and approval, pursuant to RSA 126-CC:3, to import safe prescription drugs and provide cost savings to consumers in the state.

(b) Use prescription drug suppliers in Canada regulated under the laws of Canada or of one or more Canadian provinces, or both.

(c) Ensure that only prescription drugs that can meet the federal Food and Drug Administration's safety, effectiveness and other standards are imported by or on behalf of the state.

(d) Import only those prescription drugs expected to generate substantial cost savings for consumers in the state.

(e) Ensure that the program complies with the transaction and tracing requirements of 21 U.S.C. sections 360eee and 360eee-1 to the extent feasible and practical prior to imported prescription drugs coming into the possession of the licensed United States drug wholesaler and that the program complies fully with those federal requirements after imported prescription drugs are in the possession of the licensed drug wholesaler.

(f) Prohibit the distribution, dispensing, or sale of imported prescription drugs outside of the state.

(g) Recommend a method to finance the program which will not jeopardize consumer cost savings.

(h) Include an audit function.

III. The commissioner shall adopt rules pursuant to RSA 541-A, to design the program in accordance with this chapter.

IV. The department shall submit a request for approval and certification of the program to the United States Department of Health and Human Services on or before February 1, 2021.

126-CC:3 Requirements of Program. Prior to operating the program, the state agency designated to oversee the program pursuant to this chapter shall:

I. Become a licensed drug wholesaler or enter into a contract with a licensed drug wholesaler in the state.

II. Contract with one or more distributors licensed in the state.

III. Contract with one or more licensed and regulated prescription drug suppliers in Canada.

IV. Seek the appropriate federal approvals, exemptions, or agreements, or a combination thereof, as needed to enable all covered entities enrolled in or eligible for the federal 340B Drug Pricing Program to participate in the program to the fullest extent possible without jeopardizing their eligibility for the 340B Program.

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V. Consult with health insurance carriers, employers, pharmacies, pharmacists, health care providers, and consumers.

VI. Develop a registration process for health insurance carriers, pharmacies, and health care providers authorized to prescribe and administer prescription drugs that are willing to participate in the program.

VII. Create a publicly accessible website for listing the prices of prescription drugs to be imported under the program.

VIII. Create an outreach and marketing plan to work with health carriers and provider associations to generate public awareness of the program.

IX. Develop a 2-year audit work plan.

X. Conduct any other activity determined necessary to successfully implement and operate the program.

126-CC:4 Annual Report. Beginning November 1, 2021, and each November 1 thereafter, the department or other designated state agency shall submit an annual report to the chairperson of the health, human services and elderly affairs committee, the speaker of the house of representatives, the president of the senate, the house clerk, the senate clerk, the governor, and the state library relative to:

I. The prescription drugs included in the program.

II. The number of participating pharmacies, health care providers, and health insurance carriers.

III. The number of prescription drugs dispensed through the program.

IV. The estimated cost savings to consumers, health insurance carriers, employers, and the state during the previous calendar year and to date.

V. Information regarding implementation of the audit work plan and audit findings.

VI. Any other information the department, or other state agency designated to oversee the program pursuant to this chapter, deems relevant.

13:7 Consumer Protection: Acts Unlawful. Amend RSA 358-A:2, XIV to read as follows:

XIV. Pricing of goods or services in a manner that tends to create or maintain a monopoly, or otherwise harm competition, ***including the pricing of generic prescription drugs.***

13:8 New Paragraph; Managed Care Law; Prescription Drugs. Amend RSA 420-J:7-b by inserting after paragraph II-a the following new paragraph:

II-b. Every health benefit plan that provides prescription drug benefits and requires prior authorization for covered drugs in the formulary shall respond to a prior authorization request within 2 business days. The prior authorization process shall begin when the prescribing provider has submitted a request with a complete clinical rationale to the health carrier or pharmacy benefits manager. A prescription that requires a prior authorization for coverage shall be considered approved if the prior authorization process exceeds 2 business days.

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13:9 New Section; Accident and Health Insurance; Coverage for Epinephrine Auto-Injectors; Individual. Amend RSA 415 by inserting after section 6-x the following new section:

415:6-y Coverage for Epinephrine Auto-Injectors. Each insurer that issues or renews any individual policy of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance, who are residents of this state, coverage for the cost of epinephrine auto-injectors. Benefits provided under this section shall not be subject to any greater co-payment, deductible, or coinsurance than any other similar benefits provided by the insurer and shall be subject to the terms and conditions of the policy. In this section, "epinephrine auto-injector" means a single-use device used for the automatic injection of a pre-measured dosage of epinephrine into the human body.

13:10 New Section; Accident and Health Insurance; Coverage for Epinephrine Auto-Injectors; Group. Amend RSA 415 by inserting after section 18-bb the following new section:

415:18-cc Coverage for Epinephrine Auto-Injectors. Each insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance, who are residents of this state, coverage for the cost of epinephrine auto-injectors. Benefits provided under this section shall not be subject to any greater co-payment, deductible, or coinsurance than any other similar benefits provided by the insurer and shall be subject to the terms and conditions of the policy. In this section, "epinephrine auto-injector" means a single-use device used for the automatic injection of a pre-measured dosage of epinephrine into the human body.

13:11 Health Services Corporations; Applicable Statutes. Amend RSA 420-A:2 to read as follows:

420-A:2 Applicable Statutes. Every health service corporation shall be governed by this chapter and the relevant provisions of RSA 161-H, and shall be exempt from this title except for the provisions of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415-A, RSA 415-F, RSA 415:6, II(4), RSA 415:6-g, RSA 415:6-k, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-t, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, **RSA 415:6-y**, RSA 415:18, V, RSA 415:18, XVI and XVII, RSA 415:18, VII-a, RSA 415:18-a, RSA 415:18-i, RSA 415:18-j, RSA 415:18-o, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-y, RSA 415:18-z, RSA 415:18-aa, RSA 415:18-bb, **RSA 415:18-cc**, RSA 415:22, RSA 417, RSA 417-E, RSA 420-J, and all applicable provisions of title XXXVII wherein such corporations are specifically included. Every health service corporation and its agents shall be subject to the fees prescribed for health service corporations under RSA 400-A:29, VII.

13:12 Health Services Corporations; Applicable Statutes; Effective January 2021. Amend RSA 420-A:2 to read as follows:

420-A:2 Applicable Statutes. Every health service corporation shall be governed by this chapter and the relevant provisions of RSA 161-H, and shall be exempt from this title except for the

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provisions of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415-A, RSA 415-F, RSA 415:6, II(4), RSA 415:6-g, RSA 415:6-k, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, **RSA 415:6-y**, RSA 415:18, V, RSA 415:18, XVI and XVII, RSA 415:18, VII-a, RSA 415:18-a, RSA 415:18-i, RSA 415:18-j, RSA 415:18-o, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-z, RSA 415:18-aa, RSA 415:18-bb, **RSA 415:18-cc**, RSA 415:22, RSA 417, RSA 417-E, RSA 420-J, and all applicable provisions of title XXXVII wherein such corporations are specifically included. Every health service corporation and its agents shall be subject to the fees prescribed for health service corporations under RSA 400-A:29, VII.

13:13 Health Maintenance Organizations; Statutory Construction. Amend RSA 420-B:20, III to read as follows:

III. The requirements of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415:6-g, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-t, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, **RSA 415:6-y**, RSA 415:18, VII-a, RSA 415:18, XVI and XVII, RSA 415:18-i, RSA 415:18-j, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-y, RSA 415:18-z, RSA 415:18-aa, RSA 415:18-bb, **RSA 415:18-cc**, RSA 415-A, RSA 415-F, RSA 420-G, and RSA 420-J shall apply to health maintenance organizations.

13:14 Health Maintenance Organizations; Statutory Construction; Effective January 1, 2021. Amend RSA 420-B:20, III to read as follows:

III. The requirements of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415:6-g, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, **RSA 415:6-y**, RSA 415:18, VII-a, RSA 415:18, XVI and XVII, RSA 415:18-i, RSA 415:18-j, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-z, RSA 415:18-aa, RSA 415:18-bb, **RSA 415:18-cc**, RSA 415-A, RSA 415-F, RSA 420-G, and RSA 420-J shall apply to health maintenance organizations.

13:15 Severability. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

13:16 New Subdivision; New Hampshire Prescription Drug Competitive Marketplace. Amend RSA 21-I by inserting after section 95 the following new subdivision:

New Hampshire Prescription Drug Competitive Marketplace

21-I:96 Purpose and Intent. The purpose and intent of this subdivision is to authorize the commissioner of the department of administrative services, with the approval of the governor and the executive council, to establish the New Hampshire prescription drug competitive marketplace in accordance with this subdivision. The objective of this subdivision is to optimize prescription drug savings by the state of New Hampshire through the following:

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I. Adoption of a dynamically competitive reverse auction process for the state health plan selection of pharmacy benefit managers (PBM).

II. Ongoing, real-time electronic review and validation of PBM claims invoices as the foundation for reconciling pharmacy bills.

III. Conduct of market checks using technology driven evaluation of the incumbent PBM's prescription drug pricing based on benchmark comparators.

21-I:97 Definitions. In this subdivision:

I. "Department" means the department of administrative services.

II. "Pharmacy benefits manager" or "PBM" means a person, business, or other entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefits manager, that, pursuant to a contract with the health carrier or self-funded health benefit plan, manages the prescription drug coverage provided by the health carrier or self-funded health benefit plan, including, but not limited to, providing claims processing services for prescription drugs, performing drug utilization review, processing drug prior authorization requests, adjudication of grievances or appeals related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs.

III. "PBM reverse auction" means an automated, transparent, and dynamically competitive bidding process conducted online that starts with an opening round of bids and allows qualified PBM bidders to counter-offer a lower price for as many rounds of bidding as determined by the department of administrative services or its authorized representative conducting the reverse auction for a multiple health plan prescription drug purchasing group.

IV. "Price" means the projected cost of a PBM proposal or "bid" for providing prescription drug benefits pursuant to this part, to enable "apples-to-apples" comparison of the costs of competing PBM proposals over the duration of the PBM services contract.

V. "Real-time" means within no more than 12 hours.

VI. "PBA" means a participant bidding agreement entered into by all participants in the PBM reverse auction prior to participation therein.

21-I:98 New Hampshire Prescription Drug Competitive Marketplace.

I. Notwithstanding any provision of law to the contrary, a contract for the services of a PBM for the administration of benefits under this subdivision may be procured by the department, at its sole discretion, in a transparent, online competitive process, or "PBM reverse auction" as set forth in this subdivision. If the department, acting in its discretion, opts to conduct such a process, it shall procure, through the solicitation of proposals from qualified professional services vendors, the following products and services based upon price, capabilities, and other factors as determined by the department:

(a) Technical assistance from a technology operator with respect to all of the following:

(1) Evaluating the qualifications of PBM bidders.

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(2) Conducting online-automated reverse auction services to support the department or its authorized representatives in comparing the pricing for the PBM procurement.

(3) Providing related professional services.

(b) Technology platform with the required capabilities for conducting a PBM reverse auction, along with the related services of a technology operator, as described in subparagraph (a). The technology platform shall, at a minimum, possess the capacity to do the following:

(1) Conduct an automated, online, reverse auction of PBM services.

(2) Automate repricing of diverse and complex PBM prescription drug pricing proposals to enable "apples-to-apples" comparisons of the price of PBM bids utilizing 100 percent of annual prescription drug claims data available for state-funded health plans or a multiple health plan prescription drug purchasing group and using code-based classification of drugs from nationally accepted drug sources.

(3) Produce an automated report and analysis of PBM bids, including the ranking of PBM bids based on the comparative costs and qualitative aspects thereof within a 48-hour time period following the close of each round of reverse auction bidding.

(4) Perform real-time, electronic, line-by-line, claim-by-claim review of 100 percent of invoiced PBM prescription drug claims, and identify all deviations from the specific terms of the PBM services contract resulting from the reverse auction process.

(c) The contract for procurement of the technology platform and technology operator services shall not be awarded to any of the following:

(1) A vendor that is a PBM.

(2) A vendor that is a subsidiary or affiliate of a PBM.

(3) A vendor that is managed by a PBM or receives remuneration from a PBM for aggregating clients into a contractual relationship with a PBM.

(d) The vendor shall not outsource any part of the PBM reverse auction or the automated, real-time, electronic, line-by-line, claim-by-claim review of invoiced PBM prescription drug claims.

(e) With technical assistance and support provided by the technology operator, the department or its authorized representative shall specify the terms of the PBA. The terms of the PBA shall not be modified except by specific consent of the department of administrative services or its authorized representatives.

II. When and if procured, the technology platform used to conduct the reverse auction shall be repurposed over the duration of the PBM services contract as an automated pharmacy claims adjudication engine to perform real-time, electronic, line-by-line, claim-by-claim review of 100 percent of invoiced PBM prescription drug claims, and identify all deviations from the specific terms of PBM services contracts.

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III. An entity may request in writing and subject to the approval of the commissioner to participate in a joint purchasing group with the state employee and retiree group insurance program for procuring for PBM services through a PBM reverse auction or otherwise. All entities participating in a joint purchasing group shall share proportionally in the cost of procurement including all support services.

IV. If the department opts, at its discretion, to conduct a transparent, online competitive PBM selection process, as set forth in this subdivision, the processes and procedures set forth in this section shall apply to prescription drug coverage in connection with the state employee health plan for benefits under this part including for state employees, retirees, spouses, and eligible dependents in accordance with the provisions of RSA 21-I:30 and any applicable collective bargaining agreements. Any other state-funded health plan or self-funded municipal employee or other local government employee health plan, public school employee health plans, operating individually or collectively, and the health plans of the university system of New Hampshire and the community college system of New Hampshire may utilize the processes and procedures set forth in this section individually or collectively or as a joint purchasing group with the state employee health plan.

V. After completion of a first PBM reverse auction by the department for the administration of benefits under the state employee health plan, and at the discretion of the department, self-funded private sector employer or multi-employer health plans with substantial participation by New Hampshire employees and their dependents may be permitted to participate in a joint purchasing pool with state employees for conduct of subsequent PBM reverse auctions provided that such participation shall comply with and shall be consistent with all applicable state and federal law and requirements of ERISA.

VI. The state employee health plan and any self-funded public or private sector health plans that may be permitted to participate with the state in a joint PBM reverse auction purchasing pool shall retain full autonomy over determination of their respective prescription drug formularies and pharmacy benefit designs and shall not be required to adopt a common drug formulary or common prescription pharmacy benefit design. Any such entity or purchasing group shall agree, before participating in the PBM reverse auction, to accept the prescription drug pricing plan that is selected through the PBM reverse auction process.

VII. Any PBM providing services to the department or a self-funded health plan as described in paragraphs IV and V, shall provide the department and the plan the complete pharmacy claims data necessary to conduct the reverse auction and carry out their administrative and management duties.

VIII. The department may adopt rules, pursuant to RSA 541-A, to implement the provisions of this subdivision.

13:17 Effective Date.

I. Section 5 of this act shall take effect July 1, 2020.

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- II. Sections 12 and 14 of this act shall take effect January 1, 2021, at 12:04 a.m.
- III. Section 8 and 9-11 of this act shall take effect January 1, 2021.
- IV. Sections 1-4, 6 and 13 of this act shall take effect 60 days after its passage.
- V. The remainder of this act shall take effect upon its passage.

Approved: July 16, 2020

Effective Date:

- I. Section 5 shall take effect July 1, 2020.
- II. Sections 12 and 14 shall take effect January 1, 2021 at 12:04 a.m.
- III. Sections 8 and 9-11 shall take effect January 1, 2021.
- IV. Sections 1-4, 6 and 13 shall take effect September 14, 2020.
- V. Remainder shall take effect July 16, 2020.