State of New Hampshire

GENERAL COURT

CONCORD

MEMORANDUM

DATE: **November 1, 2018**

TO: **Honorable Christopher Sununu, Governor**
Honorable Gene G. Chandler, Speaker of the House
Honorable Chuck W. Morse, President of the Senate
Honorable Paul C. Smith, House Clerk
Honorable Tammy L. Wright, Senate Clerk
Michael York, State Librarian

FROM: **Representative Erin T. Hennessey, Chairman**

SUBJECT: **Final Report on RSA 126-A:77, HB 1418**
Chapter 350:1, Laws of 2018

Pursuant to RSA 126-A:77, HB 1418, Chapter 350:1, Laws of 2018, enclosed please find the Final Report of the Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs.

If you have any questions or comments regarding this report, please do not hesitate to contact me.

Enclosure

cc. commission members

FINAL REPORT

Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs

HB 1418, Chapter 350:1, Laws of 2018

November 1, 2018

MEMBERS:

Rep. Erin T. Hennessey, **Chairman**
Rep. John Plumer
Rep. Ed Butler
Sen. William M. Gannon
Tyler Brannen – Director of Health Economics, NH Insurance Department
Margaret Clifford, R. Ph. – NH Department of Health and Human Services
Jeffrey S. Newman – public member, Administrator, NH Department of Education
Emily Blatt – NH Hospital Association
Holly Stevens – Health Policy Coordinator, New Futures, **Clerk**
Richard Cohen – NH Pharmacists Association
Kevin Flynn – Business and Industry Association of New Hampshire (BIA)
April Alexander – Pharmaceutical Care Management Association (PCMA)
Dan Nam – America's Health Insurance Plans (AHIP)
Kevin Bourque – Pharmaceutical Research and Manufacturers of America (PhRMA)

CHARGE OF THE COMMISSION:

The commission was charged with studying how to achieve greater transparency in pharmaceutical costs by identifying and analyzing certain critical prescription drugs and their role in overall health care spending in the New Hampshire and by analyzing the amounts rebated by drug manufacturers for certain high cost and high utilization prescription drugs. The study was to include, but not be limited to:

A. Studying strategies available to achieve greater transparency in pharmaceutical costs by identifying and analyzing certain critical prescription drugs and their role in overall health care spending and the impact of price increases on patients and their families.
B. Reviewing legislative efforts in other states and taking advantage of any other analysis by outside organizations or foundations.
C. Analyzing the impact of drug prices on insurance premium costs, consumer out-of-pocket costs for prescription drugs, and state and county purchasing of prescription drugs.
D. Analyzing the potential impact of transparency in relation to the practices of pharmaceutical manufacturers and pharmacy benefits managers, including how research and development, marketing, and rebates affect drug prices.

E. Proposing changes to New Hampshire law, as needed, to reduce the rising cost of pharmaceuticals.

The commission was also charged to study the role pharmacy benefit managers (PBMs) play in the cost, administration, and distribution of prescription drugs; if greater transparency in pharmaceutical costs to purchasers would lower costs in overall health care spending in New Hampshire; and analyzing the amounts rebated by drug manufacturers for prescription drugs passed to purchasers and patients. The goal shall be to determine if any changes to New Hampshire laws could reduce the rising cost of pharmaceuticals to purchasers or patients.

PROCESS AND PROCEDURES:

To accomplish the above stated charge, the commission met six times, between August 28, 2018 and October 30, 2018, to solicit information from stakeholders in the pharmaceutical supply chain as well as patients and patient advocates.

The following individuals made presentations to the commission:

- Holly Stevens, Health Policy Coordinator, New Futures
- Tyler Brannen, Director of Health Economics, NH Insurance Department
- Margaret Clifford, R.PH. NH Department of Health and Human Services
- April Alexander, Pharmaceutical Care Management Association (PCMA)
- Kelly Ryan, Senior Director of State Policy, PhRMA
- Robert Popovian, Vice President, Pfizer
- Cara Kelly, Director of US Public Policy, Celgene
- Richard Cohen, NHPA
- Daniel Nam, AHIP
- Paula Rogers, Anthem Blue Cross and Blue Shield
- Charlie Arlinghaus, Commissioner, and Joyce Pitman, Manager, Risk Management Unit, Department of Administrative Services
- Robert Stoker, Patient Advocate
- Corey Greenblatt, Global Healthy Living Foundation
- Rep. Dianne E. Schuett, Patient
- Lucy Hodder, UNH Director of Health Law and Policy Program

Meeting minutes from each of the above presentations are included in Appendix A of this report.

HISTORY:

The growing cost of prescription drugs in the U.S. is one of the most challenging issues facing healthcare consumers. While some of the growth in pharmacy spending relates to advances in pharmaceuticals and improved health outcomes, not all increases in drug spending relate to improvements. As pharmaceutical prices and spending rise,

consumers, employers, governments look to lawmakers to provide transparency in pharmaceutical pricing and legislation that would put downward pressure on prices.

HB1418 (2018) as introduced in January, required the NH Commissioner of the Department of Health and Human Services (DHHS), in consultation with the Insurance Commissioner, to develop a list of certain critical prescription drugs. The original bill required drug manufacturers to report certain information about the costs associated with the drugs on the compiled list and required the DHHS Commissioner to issue an annual report on the role of the drugs on overall health care spending in New Hampshire. This bill was amended in the House to establish a 15-member commission to study pharmaceutical drug costs, including the impact of rebate programs and the role of pharmacy benefit managers (PBMs).

Another bill adopted this year, SB481, established a 4-member legislative committee to study the impact of pharmacy benefit manager operations on the cost, administration, and distribution of prescription drugs.

Many of the HB1418 commission and SB481 committee meetings were held jointly because of their similar charges. The report from the SB481 committee can be found at the New Hampshire State Library.

A number of states have adopted legislation addressing prescription drug costs and pricing in recent years. A National Conference of State Legislatures (NCSL) report, dated May 2018, summarizing these can be found in Appendix C. This memorandum also includes information on lawsuits filed in response to laws adopted in California, Maryland and Nevada and information about the implementation of a Vermont law. Finally, it includes a list of laws adopted in New Hampshire in the last three years relative to prescription drug benefits in health insurance policies and contracts between insurers or PBMs and pharmacies.

FINDINGS:

To study how to achieve greater transparency and pharmaceutical costs, the commission attempted to identify certain critical prescription drugs and analyze their role in overall healthcare spending in New Hampshire, both on the state and county level. This task proved to be too difficult to complete in the timeframe given to the commission. The commission reached out to three sources and attempt to receive and analyze this information. The sources of information and the results of our study are as follows:

- NH Department of Administrative Services (Admin Services)
  - Admin Services provided the commission with information on the State of New Hampshire health benefit plan (HBP) which is a self-funded, employer-sponsored health benefit plan for employees and dependents and retirees and spouses.
  - HBP contracts with a PBM to manage the plans prescription benefits.
  - Governor and Council recently approved new 3-year contract (1/1/2019 – 12/31/2021) with Express Scripts for $213M. Express Scripts will serve as the third party administrator and process claims as collectively bargained for employees and as approved by the legislature for retirees.

  - Admin Services was able to provide the commission with the top 25 drugs by plan cost. However, the plan cost is the gross cost of the drug rather than the cost net of any rebates received by and passed through to the HBP. Because the HBP receives rebates from its PBM in aggregate, the net cost of each drug is not known and thus could not be studied by the commission. See Appendix D for the HBP 2017 Plan Cost overview.
- NH Department of Health and Human Services (DHHS)
  - During the commission's time of study, DHHS had an open RFP for the state's Medicaid Care Management (MCM) program. DHHS could not release any financial information related to pharmaceutical costs in order to ensure the RFP process was fair and competitive. As a result, the commission could not gain access to the information needed to complete its study.
- Grafton County
  - The commission reached out to Grafton County to gather information on pharmaceutical spending at the county level. Because of the time constraints on the commission, county was unable to gather this information in a timely manner in order for the commission to complete its study.

The commission also heard from patients and patient advocacy groups on the impact of price increases on patients and their families as well as how PBM formulary decisions impact drug access and price to the consumer.

- Because copays for consumers continue to rise, consumers have started to rely on copay cards, offered by pharmaceutical manufacturers, to defray some of their prescription costs. These cards have become integral for some patients to ensure they are able to afford their prescriptions.
- Although drug copay cards serve an immediate price relief for the consumer, the commission heard testimony that drug copay cards undermine benefit designs created to encourage lower-cost options, particularly when discount cards are used by the pharmaceutical industry to encourage consumers to remain on a brand product when a generic equivalent is available and, absent reduction of cost-sharing by the copay card, significantly less expensive than the brand. A recent study showed that copay cards increased branded utilization by over 60 percent (entirely by reducing the sales of bioequivalent generics), and led to higher total spending of $30 to $120 million per drug in the five years following the market entry of a generic competitor.[1]
- Additionally, the commission heard testimony from a patient whose access to a long-standing prescription was denied because of a PBM formulary change. And, the price of the long-standing prescription was lower than the formulary alternative. After a long encounter with the PBM, the patient was ultimately allowed the original drug.
- For patients, copay cards and formulary changes are both examples of how direct and indirect pharmaceutical costs to consumer need more transparency.

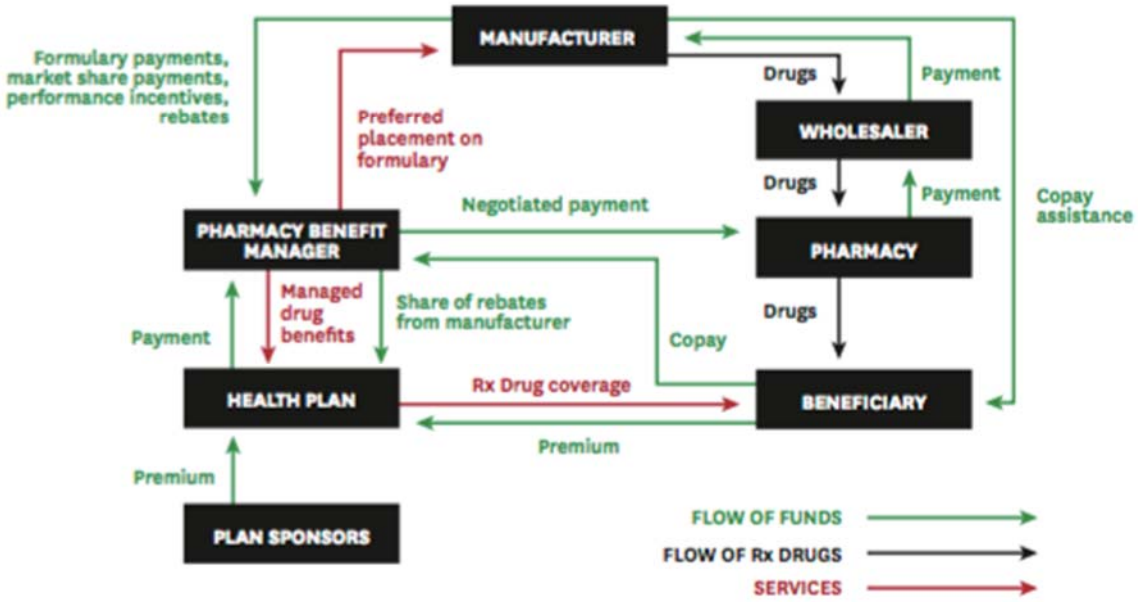
The commission studied legislation passed by other states to bring more transparency to pharmaceutical prices and lower pharmaceutical costs – see Appendices B & C (May 2018) for detailed legislation from NH and other states. Most of the legislative efforts have come in the past few years and it is too early to tell if these laws will have an effect on transparency

[1] Leemore Dafney, et al. "When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization." (2016).

or lower costs. Also, many of the laws are being challenged in court and the outcomes are not known yet.

The complexity of the pharmaceutical supply chain illustrates the need for greater transparency on many levels. In attempting to analyze the impact of drug prices on insurance premium costs the commission looked at the relationship between pharmaceutical manufacturers and PBMs and the relationship between PBMs and health plans. Figure 1 below is a good example of the relationship flow of money, drugs, and services in the pharmaceutical supply chain.

Figure 1: Conceptual model of the flow of products, services and funds for non-specialty drugs covered under private insurance and purchased in a retail setting



Source: N. Sood, et. al., *The Flow of Money Through the Pharmaceutical Distribution System*, June 2017, p. 2, https://healthpolicy.usc.edu/wp-content/uploads/2017/06/USC_Flow-of-MoneyWhitePaper_Final_Spreads.pdf

As noted above, the commission heard testimony from representatives of health plans, pharmacies, manufacturers, and PBMs. Each of these entities serves a purpose in the supply chain and benefits the consumer while also adding costs through entity operating costs and profits.

Depending on the health program type, e.g., Medicare, Medicaid, private insurance in the fully insured market, the commission heard testimony that pharmaceutical costs account for between 10% and 19% total healthcare costs. Per the NH Insurance Department "Final Report of the 2016 Health Care Premium and Claim Drivers" report, pharmacy continues to be the largest driver of overall medical trend from 2014-2016.

The commission heard testimony from the PBMs that rebates from the pharmaceutical manufacturer to the PBM help to lower healthcare premiums because, in many cases, these rebates are passed along to the health plan. However, it is unclear as to what would happen

to pharmaceutical pricing, and thus overall healthcare costs, if the manufacturers no longer offered rebates to PBMs or copay coupons to the consumer.

RECOMMENDATIONS:

Because of the limited time the commission was given to work, it was not able to accumulate enough information to complete its study. Therefore, the commission cannot recommend any legislative actions to address its study findings.

Below is a compilation of ideas that individual commission members think will help to increase transparency in pharmaceutical costs and lower costs in overall healthcare spending in New Hampshire.

- Monitor efforts at the federal level that seek to achieve greater transparency in pharmaceutical costs;

- Legislation that would establish an ongoing commission, or extension of the HB1418 commission, to continue to address the charge of the HB1418 commission;

- Legislation that would require PBMs include all lower cost FDA approved drugs in their formularies if they are at a lower cost to the patient, and approved for the same purpose, as the drug on the approved formulary;

- Legislation similar to other states that requires transparency and disclosure on the part of pharmaceutical manufacturers when increasing wholesale drug costs on drugs already in distribution and publish all disclosure information on the state's website;

- Ensure that any legislative changes made benefit the bottom line for patients while ensuring savings for the government or private insurance providers, i.e., the legislation lowers overall healthcare costs;

- Study what patients are charged for drugs at pharmacies when a patient pays above copay price because their deductible and coinsurance have not been met. Ensure the cost share price charged is in agreement with what their PBM would pay the pharmacy plus any applicable copay;

- Study the cost of pharmaceuticals to the patient under a plan's prescription benefit compared to the same plan's medical benefit;

- Legislation relating to PBMs that includes discrete definitions; requires licensure if doing business in the State of NH; sets out specific required business practices; sets out transparency requirements related to rebates;

- Legislation relating to a manufacture's introduction of new high-cost prescription drugs (see S. 92 Vermont p. 21-23);

- Legislation that would codify the NHID rules relating to consumers receiving the lowest cost at the pharmacy counter (Ins 2704 rule);

- Legislation that would allow consumers to contact either the AG or the Commissioner of the NHID in cases of price gouging, in tandem price raising, or the introduction of new high-cost prescription drugs and would enable the AG/Commissioner to request certain information from the health insurance companies, wholesalers, pharmacies, PBMs, and manufactures so that an investigation could be conducted;

- Legislation that would examine the impact of copay coupon programs on the cost of pharmaceuticals;

- State requires health insurance payers use the comparative effectiveness tool to set the drug prices for manufacturers and set ceilings on the prices;

- State requires manufacturer to rely on ICER comparative effectiveness tool to inform the price passed through the PBM; and

- Legislation that would implement the recommendations from the NH Pharmacists Association, see Appendix E.

I would like to thank all the members of the commission who were instrumental in this study. I would also like to acknowledge all those who testified before the commission and assisted the commission in our study.

Respectfully submitted on behalf of the Commission,

Rep. Erin T. Hennessey

APPENDICES LISTING

Appendix A

Commission meeting minutes

Appendix B

New Hampshire legislative bills signed into law from 2016 – 2018 related to the charge of this commission

Appendix C

NCSL report, "Recently Enacted Laws Affecting Pharmaceutical Costs, Pricing, and Payment 2015-2017"

Appendix D

NH HBP 2017 Plan Cost

Appendix E

Letter to the commission from the NH Pharmacists Association dated 10/22/18

Appendix A

Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs

Tuesday, August 28, 2018

10:00 AM

Legislative Office Building Room 307

MINUTES

Commission members in attendance:

Representative Erin Hennessey, Representative Edward Butler, Senator William Gannon, Kevin Bourque (PhRMA), Kevin Flynn (BIA), Holly Stevens (New Futures), Jim Potter (NH Medical Society), Tyler Brannen (NH Insurance Department), Emily Blatt (NH Hospital Association); Lauren Rowley (for April Alexander PCMA), and Tricia Lucas (for Margaret Clifford DHHS).

Commission members absent:

Representative John Plumer, Afraim Botros (AHIP), Jeffrey S. Newman (Public Member), representative of the New Hampshire Pharmacists Association

First order of business was election of chair and clerk.

Representative Butler nominated Representative Hennessey as chair which was seconded by Jim Potter. The members unanimously voted Representative Hennessey as chair of the Commission.

As chair, Representative Hennessey asked for volunteers for clerk. Holly Stevens volunteered, and the members expressed no opposition to Holly Stevens being elected clerk.

All the members introduced themselves and stated what they hoped to see come out of the Commission.

All members reviewed the charged of the Commission and Chair Hennessey orally reviewed specific points of the charge, and also mentioned that there is a study committee that is looking at the impact of PMBs that was created by SB 481 and that she (Chair Hennessey) will be reaching out to Senator Soucy to coordinate regarding the overlap of this Commission and the SB 481 Committee.

Holly Stevens gave a presentation on laws passed by other states that require drug manufacturers to report the reasons behind dramatic price increases and that require PBMs to register with the

state or require PBMs to disclose information that would create greater transparency. She provided the following handouts:

A Glossary of All Terms Pharma by Jane Horvath, June 15th 2018 Shutterstoch.com

State Remedies for Costly Prescription Drugs, Legis Brief NCSL Aug. 2018, Vol. 26, No. 29

Recently Enacted State Laws Affecting Pharmaceutical Costs, Pricing and Payment, May 2018 Prescription Drug Resource Center NCSL

Pharmacy Benefit Manager Model Legislation: Question and Answers, Jane Horvath, August 9th 2018, NASHP

Legal Challenges of Rx Drug Laws Passed in 2017 will Shape Future States' Cost Containment Legislation, Jane Horvath, March 2018, NASHP

Comparison of State Transparency Laws: What they Require and What Enforcement Action States Can – or Can't – Take, Center for State Drug Pricing, NASHP

State Prescription Drug Legislative Tracker 2018, NASHP

Jodi Grimblias pointed out that the 2018 NASHP legislative tracker has some mistakes on it, and pointed to some of the NH bills. Holly Stevens recommended that if anyone reads about a bill on this chart the recommendation would be to go to the corresponding state's website and double check on the actual bill text and status. Holly Stevens stated that she had seen all the bills referred to in her presentation and was not solely relying on the chart for the presentation.

Representative Hennessey asked what multi-sourcing meant. Holly Stevens explained that multi-sourcing was when a drug had multiple manufacturers.

Lauren Rowley provided an explanation of direct and indirect remuneration.

Tyler Brannen of the Insurance Department gave a presentation and provided an overview of which entities are regulated by the Insurance Department. PBMs can fall under the purview of the Insurance Department. Representative Hennessey asked for an example, and Tyler gave the example of the standardized prior authorization form for medications that the carriers and the PBMs have to use. He also spoke about the data that is currently being collected by the Insurance Department from the carriers. Tyler explained the difference between rebates and coupons. He provided the following handout:

New Hampshire Insurance Department Final Report of the 2016 Health Care Premium and Claim Cost Drivers, December 1, 2017, pages 40-45 plus the cover page

The Commission discussed who the members would like to hear testify. Suggestions were as follows:

- PCMA
- Drug Manufacturer
- Pharmacist
- Consumer group- Multiple Sclerosis was suggested
- Insurers

An audience member mentioned a flow chart created by PhRMA that shows how the money flows through the system and agreed to provide it, or PhRMA will provide it.

Chair Hennessey asked that if anyone has further suggestions for groups or individuals to testify that they could emails or call her.

Next meeting times were discussed. Meetings will be on Tuesdays from 10 AM – 12 noon. The next meeting will be on September 4, 2018.

The meeting was adjourned.

Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs

Tuesday, September 18, 2018

10:00 AM

Legislative Office Building Room 301-303

MINUTES

Commission members in attendance:

Representative Erin Hennessey, Representative Edward Butler, Senator William Gannon, Holly Stevens (New Futures), Jim Potter (NH Medical Society), Tyler Brannen (NH Insurance Department), Emily Blatt (NH Hospital Association), April Alexander (PCMA), Margaret Clifford (DHHS), Richard Cohen (NH Pharmacists Association), and Daniel Nan (AHIP).

Commission members absent:

Representative John Plumer, Kevin Bourque (PhRMA), Jeffrey S. Newman (Public Member), and Kevin Flynn (BIA)

Representative Hennessey called the meeting to order. The meeting was a joint meeting of the Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs and the Committee to Study the Impact of Pharmacy Benefit Manager Operations on Cost, Administration, and Distribution of Prescription Drugs. Therefore, also in attendance were Representatives Valeria Fraser and David Luneau.

Presentation from Margaret Clifford- DHHS about the Medicaid fee for service program prescription drug spend and rebate program.

Ms. Clifford explained that she was asked by the Chair to find out and report the Medicaid drug spend and rebates for the past 10 years but due to the recent release of the RFP for the reprocurement of MCOs, she was not able to obtain this information. She was told that this is proprietary information that cannot be shared at this time because it could influence the RFP process.

Chair Hennessey asked Ms. Clifford if she knew the deadline for the RFPs. Ms. Clifford did not, but stated she would get back to the Commission. Representative Butler asked that if at any point it could be shared, the representatives would like to have the information.

Ms. Clifford provided a presentation about how the rebate program works within the Medicaid fee for service program and provided a hand out (the MCOs have their own reimbursement structure, and therefore, were not included in this presentation).

Ms. Clifford provided hand outs for the top 25 drugs by cost and top 25 drugs by utilization

Medicaid has carved out Hep C and hemophelia and 2 other rare drugs that are paid for by fee for service, so even if a person is being served within an MCO those prescription drugs are paid for by fee for service program. This is why the fee for service list has different drugs on the top of its list for high cost drugs.

April Alexander of PCMA provided a presentation on Pharmacy Benefit Managers that she called “PBM 101.”

Representative Butler asked Ms. Alexander about other relationships and if she could help the Commission to understand them? She stated there is not a lot of transparency, that there may be volume discounts for pharmacies, and discounts to pharmacies for paying early. She stated that either the wholesaler or the manufacture could be providing the discount, but she is not sure about these relationships. She was not able to provide the Commission information about these other relationships because she doesn’t have information about them.

Chair Hennessey asked if any of the PBMs do wholesale selling of drugs. Ms. Alexander stated she does not think so, but she will find out.

Ms. Alexander agreed to provide the language of the California bill that put restrictions on co-pay coupons.

There were several questions from Commission members about the correlation study conducted by PCMA and represented by the graph contained in the presentation. Ms. Alexander agreed to take the questions back and look into the graph and study further so that she could answer the questions. Chair Hennessey asked is the price growth overall growth or year over year growth. Ms. Black asked if the graph would look different if the individual drugs were parsed out rather than being grouped into categories. Ms. Alexander also agreed to provide the full report for the Commission so that the Commission members could look at it.

Gary Merchant the President of the NH Board of Pharmacy was scheduled to present was not in the room when Ms. Alexander finished and therefore was rescheduled to present at a later time.

Representative Butler asked that the Commission members start thinking about what can be done legislatively regarding drug price transparency.

Chair Hennessey announced the next meeting will be Tuesday October 2, 2018 at 9 AM and the pharmacists and PhRMA will present. Following that the next meeting will be Tuesday October 9, 2018 at 10 AM and the insurance companies, AHIP, and administrative services will meet.

Chair Hennessey adjourned the meeting.

Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs
Tuesday, October 2, 2018
9:00 AM
Legislative Office Building Room 301-303
MINUTES

Commission members in attendance:
Representative Erin Hennessey, Representative Edward Butler, Representative John Plumer, Senator William Gannon (arrived at 10:00 AM), Jennifer Patterson (for Tyler Brannen NHID), Holly Stevens (New Futures), Kevin Flynn (BIA), Daniel Nam (AHIP), Margaret Clifford (DHHS), Emily Blatt (arrived at 10:00 AM NH Hospital Association), Richard Cohen (NHPA), April Alexander (PCMA), Kevin Bourque (PhRMA).

Commission members absent:
Jeffrey S. Newman (Public Member)

Chair Hennessey called the meeting to order. The meeting was a joint meeting of the Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs and the Committee to Study the Impact of Pharmacy Benefit Manager Operations on Cost, Administration, and Distribution of Prescription Drugs. Therefore, also in attendance were Representatives Valeria Fraser and David Luneau and Senator Donna Soucy.

PhRMA gave the first presentation. It had three people provide different presentations.

The first PhRMA presenter was Kelly Ryan, the Senior Director of State Policy for PhRMA. She provided a PowerPoint handout.

Ms. Ryan first spoke about some surveys that PhRMA had done that are not captured within the PowerPoint handout. She stated that in these surveys they had asked patients what kind of transparency is important to them and that the surveys indicated what the patients want to know is what they are going to pay in out of pocket costs. She stated that they care more about what they are going to pay in out of pocket cots and that they care less about actual costs/ whole sale costs or research and development costs.

In relation to specific slides, she stated that (slide 4) in 2014 the spike was due to the Hep-C drugs hitting the market. In response to a question, (slide 5) the percentage of hospital care spending includes any pharmaceuticals that are administered while a patient is in the hospital. In response to a question (slide 9) the net revenue is what goes back to the manufacturer and rebates are what show up in the other third of the spending that is retained.

April Alexander (PCMA) made comments about slide 7 and 10- noting that the FTC reviewed the mergers of the PBMs and that found that they were not damaging competition. She also stated that slide 11 is just an example where someone is in deductible phase, and it doesn't show what the insurer does with rebate money, and how it follows down to lower premiums.

Daniel Nam (AHIP) asked Ms. Ryan what she thought the pharmaceutical industry could do to help lower drug costs? Ms. Kelly stated that there needed to be a conversation about the whole system, and that the pharmaceutical industry itself, alone and in isolation cannot do anything. Daniel Nam stated that the Hep-C drug development and market was very different and was not the norm and more of an outlier.

Jennifer Patterson (for Tyler Brannen NHID) asked if on slide 4 it was after discounts and rebates and mentioned that the insurance department is working on looking at discounts and rebates to gain more transparency. She asked how can system be changed? Ms. Ryan stated that on slide 4 the price increases are after discounts and rebates are factored in and that that flat rates could be set instead of list price. She also said that incentives needed to be removed every step of the way so that price is the price. Attorney Patterson asked what can state legislators can do? Ms. Ryan stated that they needed to keep their focus on the state and what state can do. She stated that the state cannot mess with the patent system. She stated that the focus should be on whether patients have all the information they need about their health insurance plans and what drugs are on their formularies, etc.

The second PhRMA presenter was Robert Popovian, Vice President of Pfizer. He stated he was a pharmacist and that he had worked for a PBM in the past and now works for Pfizer. He did not provide a copy of his slides and stated that he would need to ask his legal department if he was able to provide a copy of them. He stated he could provide all the citations that supported the points on his slides. The below is a brief summary of his presentation since he did not provide the slides.

He stated the tactics that PBMs use provide incentives that increase prices. He stated that everybody benefits from high drug prices except for the patients and the federal government. He stated a small number of patients are subsidizing the majority and that drugs are NOT driving premium increases. He stated we do have biosimilar competitive market and that drugs are not negotiated on behalf of patients. He stated that in all other aspects of health care, insurance companies negotiate prices on behalf of patients but that this does not happen with pharmaceuticals. He mentioned the concessions that go to the middlemen (PBMs, insurers) and asked where do they go. He stated 35-40% go to hospitals or are government mandated. He stated that he sells $1 and gets sixty cents back. He said premiums are impacted by the cost of pharmaceuticals but not to the point that people are saying they are. He said the solution was to share the savings. He also stated that Bio-similars were not being adopted into the market place and needed to be. He also mentioned spread pricing that the PBMs use. He stated that the 340b program is being abused and drugs are going into general distribution. He also stated that the consolidation of hospital and doctor's practices have increased the costs of drugs being administered in the office/hospital setting because hospitals charge more to administer medications than outpatient doctor's offices. He stated that new payment models are needed, such as, if a drug does not work than the drug manufacturer needs to refund the money. He also mentioned the PBMs charging the manufactures fees.

During Mr. Popovian's presentation Daniel Nam asked why the manufactures gave rebates. After a brief discussion between the two, it was agreed that this was done for a gain of the market share, so there is some value going back to the manufactures that is not monetary in nature.

Richard Cohen (NHPA) mentioned that the manufactures were doing things to extend patent protection like creating Mash-up- combo of 2 drugs and is new brand name.

The third PhRMA presenter was Cara Kelly, the Director of US Public Policy, Celgene. Ms. Kelly took the Commission through and exercise called Start up CEO-where a person decides how to price a medication. During the exercise, you are the CEO of a start-up drug manufacturer and you decide what type of drug you are going to make. You then decide what you are going to charge for it based on data that is given to you throughout the exercise.

Daniel Nam (AHIP) asked if this would be different if it were a larger well-established company? Ms. Kelly stated that she believed the numbers and results would be different.

Richard Cohen (NHPA) gave the last presentation. He provided a hand-out. His presentation included information on PBMs and he explained the differences between cash discount coupons and drug manufactures coupons. He also provided information on the amount of money that PhRMA and the PBMs have spent in lobbying this year.

Chair Hennessey asked about how a pharmacy comes up with the usual and customary price. Mr. Cohen stated that there are computerized price schedules and that the pharmacies set the price slightly higher than they expect to get from the insurance company. He stated the price is set by the corporate office.

April Alexander (PCMA) asked how much the pharmacist associations have spent on lobbying? Mr. Cohen said he did not know but would find out. Ms. Alexander also asked the source for the data point that there are 25 independent pharmacies in the state. Mr. Cohen said that the source is Mike Fuller- Board of Pharmacy. Mr. Fuller, who was in the audience, stated there are 19 are in the state right now. Ms. Alexander asked where he got that number. Mr. Fuller stated he oversees all the pharmacies, so he knows how many there are. He stated an independent pharmacy has less than 3 outlets.

Senator Gannon asked why all the independent pharmacists have disappeared and asked specifically if is it because they are too small to compete? Mr. Cohen stated that is the reason because you can’t negotiate a contract being only one person. Senator Gannon asked if all the independents had thought of getting together to negotiate together. Mr. Cohen stated he was trying to get them together but that there was a lot of apathy due to the chain stores and PBMs.

Chair Hennessey announced that due to the other presentations running long the patient advocacy group presentations are being moved to next meeting, which will be on October 9, 2018 at 10:00 AM in LOB 306.

A motion was made to approve the meeting minutes for the August 28, 2018 meeting and the September 18, 2018 meet. The motion was seconded, and the minutes for both meetings were approved by the Commission members present except for Attorney Patterson who abstained from the vote since she was not at either of the previous meetings.

Chair Hennessey adjourned the meeting.

Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs

Tuesday, October 9, 2018

10:00 AM

Legislative Office Building Room 308

MINUTES

Commission members in attendance:

Representative Hennessey, Representative Butler, Jeffrey Newman (public member), Daniel Nam (AHIP), April Alexander (PCMA), Margaret Clifford (DHHS), Tyler Brannen (NHID), Kevin Flynn (BIA), Richard Cohen (NHPA), Emily Blatt (NHHA), Kevin Bourque (PhRMA), and Holly Stevens (New Futures)

Commission members absent:

Representative John Plumer and Senator William Gannon

This meeting was a joint meeting of the Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs and the Committee to Study the Impact of Pharmacy Benefit Manager Operations on Cost, Administration, and Distribution of Prescription Drugs. Therefore, Senator Donna Soucy was also present and chaired the meeting.

Senator Soucy called the meeting to order and requested the first presentation.

The first presentation was from the state's Administrative Services. The presentation was given by Joyce Pitman, the Director of risks and benefits and Charlie Arlinghaus, Commissioner of the Department of Administrative Services. They provided an overview of the state's Health Benefit Plan with a focus on the prescription drug benefit and the PBM contract. Mr. Arlinghaus stated that the PBM contract requires 100% pass through of all rebates, but that the PBMs can keep any profit they make from spread pricing. He stated that the state is not concerned with the profit that the PBM makes from spread pricing, and that his concern is getting the best deal for the state as he would with any contract.

The second presenter was patient advocate, Bob Stoker. He stated he was involved with the COPD and Alpha one foundation and was on the Asthma and allergy foundation Board of Directors. He stated he used to be a drug rep. He spoke in support of co-pay cards discounts cards offered by manufactures. He also stated he can get drugs out of India much cheaper than here.

The third presenter was Corey Greenblatt, of Global Healthy Living Foundation (GHLF) a patient advocacy group. He stated his organization has received money from drug manufacturers. He spoke out against PBMs and stated they use deceptive practices such as rebates and spread pricing. He was asked if GHLF supports transparency in all parts of the pharmaceutical system. He stated they do. He was asked what suggestions he has for manufacturer transparency. He

stated he did not have specific suggestions for manufactures. He was asked if he had ever testified in favor of manufacturer transparency, and he stated he had not.

The fourth presenter was Holly Stevens of New Futures who provided a consumer prospective of rising drugs costs when drugs are acquired, drug prices risings in tandem or in response to an epidemic, or come on the market at a very high cost.

The fifth presenter was Daniel Nam, AHIP. His presentation focused on how co-pay coupons protect PhRMA's market share and that rebates have little effect on the increase of drug prices. He stressed that the Commission should be focusing on the drug makers because they make up the largest part of the drug supply chain.

The sixth presenter was Paula Rogers, Public relations at Anthem. She stated that pharmacy is one of their biggest items and they have a relationship with ESI (that is there PBM). She stated that PBMs do important work that negotiate on behalf of payors, and that it is a complex system. She stated a person is exposed to the list price at the pharmacy. She stated that Anthem is moving to a new PBM, that they are developing their own PBM. She stated they are also looking at pharmacy in medical setting as well as in the pharmacy setting. She stated that the Commission could go to Ingenio-rx.com to get some preliminary information. She also mentioned the NASHP RFP for a vendor to build a data base as a resource for states working on drug price transparency including NH.

Paula was asked what would be helpful for an insurance company to know? She said she would send along Anthem's response to a Request for Information on how to drive down drug costs.

The seventh presenter was April Alexander, PCMA. Her presentation provided an overview of PBMs, including what services they provide, what regulations they are subject to, and how they develop the plan formulary.

Due to time constraints, Lucy Hodder's, UNH Director of Health Law and Policy Program, presentation was pushed to the next meeting.

Representative Hennessey announced the next meeting will be October 16th at 10:00 AM.

Senator Soucy adjourned the meeting.

Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs

Tuesday, October 16, 2018

10:00 AM

Legislative Office Building Room 307-308

MINUTES

Commission members in attendance:

Representative Erin Hennessey, Representative Edward Butler, Senator William Gannon, Jake Berry (for Holly Stevens New Futures), Tyler Brannen (NH Insurance Department), Emily Blatt (NH Hospital Association), Sam Hallemeier (for April Alexander PCMA), Margaret Clifford (DHHS), Richard Cohen (NH Pharmacists Association), Andrew Antrobus (for Kevin Bourque PhRMA), Daniel Nam (AHIP), Jeffrey S. Newman (Public Member), Kevin Flynn (BIA)

Commission members absent:

Jim Potter (NH Medical Society), Representative John Plumer

Representative Hennessey called the meeting to order. The meeting was a joint meeting of the Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs and the Committee to Study the Impact of Pharmacy Benefit Manager Operations on Cost, Administration, and Distribution of Prescription Drugs. Therefore, also in attendance were Senator Donna Soucy and Representatives Valeria Fraser and David Luneau.

The meeting opened with a presentation from Lucy Hodder, director of Health Law and Policy Programs at the University of New Hampshire Law School. She provided a PowerPoint handout.

Dir. Hodder provided an overview of New Hampshire's prescription drug system, stating that prescriptions are both delivered and paid for differently than other parts of the health care system. She suggested that across the country there is intense pressure to move health care payments toward a value-based model, meaning you're paying for the best outcome and not seeking the lowest cost. The shift to high deductible insurance plans has made the cost to consumers more acute. Further, there has been a movement toward consolidation within the health care system.

The lack of transparency for prescription drug prices is a serious challenge for consumers, Dir. Hodder said. New Hampshire's health care community will have to figure out how best to address Bio-similars – generic forms of more complex pharmaceuticals – which are expected to enter the market with greater frequency. Further, regenerative medicine products entering the market will be hugely expensive. New Hampshire must prepare to manage that delivery of care to those who need it.

Dir. Hodder stated that New Hampshire has compelling public health needs, including tobacco, obesity/diabetes, heart disease and stroke, and that regulation can help to provide transparency and level the playing field to address some of those needs.

Dir. Hodder reviewed national data on health care expenditures and enrollments, reporting that 10 percent of health care spending across the country is on prescription drugs. New Hampshire does track health care spending information, but not as thoroughly as other states, she said.

In New Hampshire, pharmacy costs continue to be one of the largest driver of overall medical cost trends, according to Dir. Hodder. Between 2014-2016, pharmacy claims trended up 15 percent in New Hampshire's fully insured markets, compared to 5 percent for inpatient services, she said. Specialty pharmacy has outpaced other pharmacy costs.

In New Hampshire, random price spikes have impacted consumers in recent years, Dir. Hodder said. She cited Hepatitis C drugs as an example, which left the state with no ability to respond to a public health need.

Dir. Hodder stated that neighboring states like Maine, Massachusetts, Rhode Island and Vermont have all taken steps to increase access to information and provide transparency assistance. In New Hampshire, legislators should consider what the Attorney General's office is seeing and doing in response.

The issue of transparency is further complicated by industry mergers, like those between CVS and Aetna, or Cigna and Express Scripts, which are taking place all around and providing very little information.

Chair Hennessey asked Dir. Hodder whether she felt it would have been better to allow physicians to continue to provide free prescription drugs rather than moving to coupons. Dir. Hodder responded that circumstances have changed and it is a difficult question to answer. She reported that nationally, consumers spend about $57 billion on retails drugs, and of that, about $10 billion are covered by manufacturer coupons.

Dir. Hodder stated that New Hampshire has to consider ways to consider value in the pharmacy industry. Transparency is one way to bring in value, she said.

Rep. Butler inquired about expiring patents for insulin products, and asked if prices are going up to maximize income for companies before generics enter the market. Dir. Hodder stated that this is true.

Rep. Luneau asked about the connection between rebates and formulary. Dir. Hodder responded that this connection exists, and that some larger employers are trying to get as much transparency as they can on PBM relationships so they understand the rebates they're getting when they negotiate on aggregate across clients. Negotiations most often concern brand name drugs and only occasionally involve generics. These rebates likely drive incentives under the formulary.

Mr. Brannon asked Dir. Hodder to discuss preferences and trends for large employers dealing with PBMs separate from their health plan. Dir. Hodder responded certain large employers prefer to negotiate with PBMs separately from their health plan and will seek pass through pricing

through a fee-based structure. Smaller employers take what they can get from third party administrators, she said.

Rep. Butler said that PBMs are one area where transparency and price controls can happen. He asked Dr. Hodder if anything can be done to impact manufacturers? Dir. Hodder responded that manufacturers are subject more to federal regulations, though it's important to look into what other states are doing.

Following Dir. Hodder's presentation, Chair Hennessey moves to approve the minutes from the October 2 and October 9 meetings. Sen. Soucy seconds the motion. The motion is approved unanimously.

Rep. Dianne Schuett then addressed the commission to share her experience as a consumer. In January 2017, Rep. Schuett received notice from Express Scripts that her prescription was no longer included in the approved fomulary, she said. Express Scripts indicated she needed reauthorization from a physician, but despite her physician's efforts, the request and subsequent appeal were denied. Express Scripts suggested three alternatives, which were each exponentially more expensive. Rep. Schuett said she decided not to stay on the original medication, and after she and her physician submitted a letter to the PBM, the medication was approved and she is now covered by the original prescription.

Mr. Bob Staler, a patient advocate, discussed the rise in prices for inhalers for those experiencing COPD, asthma or other constricted airway conditions. He indicated that local pharmacists are helpful in communicating directly with patients, unlike mail order services.

Chair Hennessey inquired about recommendations for the Commission's final report. Sen. Soucy said the PBM Committee would be meeting October 24th discuss its final report. Chair Hennessey asked Legislative Services to do more research on updated laws in other states, as well as actions New Hampshire has taken in recent years.

Mr. Andy Antrobus, representing PhRMA, stated his belief that not all points of view have been presented and considered by the Commission. Chair Hennessey stated she is happy to include everyone's opinions in the report.

Rep. Luneau suggested consideration of legislation that would require that formularies include lower cost drugs approved by the FDA. Chair Hennessey stated that through collective bargaining, state plans are not allowed to drive patients to the lowest cost treatment plans.

Mr. Cohen, of the NH Pharmacists Association, suggested that the State take further steps to find out what is included in formularies, including a price breakdown and behind-the-scenes logic and profit margins.

Ms. Clifford, of the N.H. Department of Health and Human Services, mentioned there are drug look-up tools available on the department website.

Emily Blatt, of the NH Hospital Association, said she has not learned enough through the Commission to support legislation.

Rep. Butler and Chair Hennessey recommended further study, but added they would like to see the Commission make some legislative proposals.

Chair Hennessey announced the next meeting will be Tuesday, October 23 at 10 AM. The final meeting will be Tuesday, October 30, 2018 at 2 PM.

Chair Hennessey adjourned the meeting.

Appendix B

2016 HB 1210 (Chapter 221)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2016&id=310&txtFormat=html

Title: relative to prescriptions for controlled drugs by telemedicine and relative to rulemaking authority and enforcement concerning prices for filling certain prescriptions.

Summary: This bill clarifies when it is appropriate for practitioners to adjust or prescribe controlled drugs to patients by telemedicine. This bill also adds rulemaking authority for the pharmacy board concerning the price of filling prescriptions paid by a pharmacy benefits manager or insurer. The bill also adds authority for the insurance department to adopt rules for enforcement of requirements for the price of filling prescriptions.

Ins 2700 Managed Care
http://gencourt.state.nh.us/rules/state_agencies/ins2700.html

2016 HB 1608 (Chapter 228)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2016&id=505&txtFormat=html

Title: relative to uniform prior authorization forms.

Summary: This bill requires health insurers, health maintenance organizations, health services corporations, medical services corporations, and preferred provider programs to use and accept only the uniform prior authorization forms and criteria developed by the commissioner of insurance in accordance with rules adopted pursuant to RSA 541-A after December 31, 2017.

2018 SB 421 (Chapter 361)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2018&id=2009&txtFormat=html

Title: relative to insurance coverage for prescription contraceptives.

Summary: This bill clarifies insurance coverage for prescription contraceptive drugs and prescription contraceptive devices and for contraceptive services.

2018 SB 332 (Chapter 103)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2018&id=1739&txtFormat=html

Title: relative to medication synchronization.

Summary: This bill requires insurers offering health insurance policies with prescription drug coverage to allow covered persons to synchronize the dispensing dates of their prescription drugs.

2017 SB 158 (Chapter 185)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2017&id=968&txtFormat=html

Title: relative to authorization for clinician-prescribed substance use disorder services.

Summary: This bill declares that if substance use disorder services are a covered benefit under a health benefit plan, a health carrier that has authorized or approved medication-assisted treatment for such services shall not require a renewal of a prior authorization more frequently than once every 12 months.

2016 HB 1226 (Chapter 83)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2016&id=644&txtFormat=html

Title: relative to administration of pharmaceutical agents by optometrists.

Summary: This bill allows the board of optometry to review and approve certain pharmaceutical agents for use by optometrists and changes the name of the joint pharmaceutical formulary and credentialing committee.

2016 HB 1664 (Chapter 177)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2016&id=820&txtFormat=html

Summary: relative to contracts between carriers or pharmacy benefit managers and certain pharmacies.

AMENDED ANALYSIS - This bill establishes procedures for contracts between carriers or pharmacy benefit managers and contracted pharmacies.

2016 HB 1490 (Chapter 214)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2016&id=883&txtFormat=html

Title: relative to collaborative practice between pharmacists and health care practitioners and relative to certain drug take-back programs.

Summary: This bill revises the requirements for the qualifications, standards, and supervision of collaborative pharmacy practice agreements between pharmacists and health care practitioners. This bill also authorizes retail pharmacies to establish pharmaceutical drug take-back programs if their programs meet certain federal requirements. This bill also exempts household pharmaceutical wastes collected pursuant to RSA 318-E from the definition of hazardous waste.

2017 HB 455 (Chapter 223)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2017&id=579&txtFormat=html

Title: relative to the practices of pharmacy benefit managers.

Summary: This bill prohibits pharmacy benefit managers from requiring providers to attain accreditation, credentialing, or licensing other than by the pharmacy board or other state or federal entity until May 1, 2018.

2017 HB 264 (Chapter 23)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2017&id=658&txtFormat=html

Title: establishing a commission to study allowing pharmacists to prescribe or make available via protocol oral contraceptives and certain related medications.

Summary: This bill establishes a commission to study allowing pharmacists to prescribe or make available via protocol oral contraceptives and certain related medications.

2017 HB 469 (Chapter 221)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2017&id=714&txtFormat=html

Title: establishing a continuous quality improvement program for pharmacies, relative to vaccines administered by pharmacists, and relative to the authority of the insurance department on federal health care reform.

Summary: This bill:

I. Requires licensed pharmacies to establish continuous quality improvement programs to identify weaknesses in processes and systems and make appropriate corrections.
II. Adds hepatitis A, hepatitis B, Tdap, MMR, and meningococcal vaccines to the list of vaccines which may be administered by certain licensed pharmacists and nullifies the provision of SB 65 of the 2017 regular legislative session which addresses the same matter.
III. Adds provisions for the insurance department concerning federal health care reform, and repeals these provisions on July 1, 2020.

2017 SB 150 (Chapter 51)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2017&id=843&txtFormat=html

Title: relative to pharmacist administration of vaccines.

Summary: Under this bill, a pharmacy intern under the direct supervision of a pharmacist may administer immunizing vaccines.

2017 SB 65 (Chapter 149)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2017&id=932&txtFormat=html

Title: relative to vaccines administered by pharmacists.

Summary: This bill adds certain vaccines to the law which allows licensed pharmacists to administer vaccines.

2018 HB 1418 (Chapter 350)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2018&id=1023&txtFormat=html

Title: relative to establishing a commission to study greater transparency in pharmaceutical costs and drug rebate programs.

Summary: This bill establishes a commission to study greater transparency in pharmaceutical costs and drug rebate programs.

2018 HB 1746 (Chapter 92)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2018&id=1175&txtFormat=html

Title: relative to the practices of pharmacy benefit managers.

Summary: This bill prohibits certain practices of pharmacy benefit managers until June 30, 2020.

2018 HB 1791 (Chapter 164)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2018&id=1698&txtFormat=html

Title: allowing pharmacists to disclose information relative to lower cost drugs under the managed care law and relative to biological products dispensed by pharmacists.

Summary: This bill declares that a contract between an insurance carrier or pharmacy benefit manager and a contracted pharmacy shall not contain a provision prohibiting the pharmacist from providing certain information to an insured or the insurance department.
This bill also establishes requirements for dispensing and substituting biological products by pharmacists and establishes an annual education program relative to biological products.

2018 SB 333 (Chapter 104)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2018&id=1742&txtFormat=html

Title: relative to pharmacy interns and vaccinations.

Summary: This bill allows a pharmacy intern under the supervision of a pharmacist to administer hepatitis A, hepatitis B, Tdap, MMR, and meningococcal vaccines.

2018 SB 481 (Chapter 143)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2018&id=1920&txtFormat=html

Title: establishing a committee to study the impact of pharmacy benefit manager operations on cost, administration, and distribution of prescription drugs.

Summary: This bill establishes a committee to study the impact of pharmacy benefit manager operations on cost, administration, and distribution of prescription drugs.

2018 SB 591 (Chapter 236)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2018&id=1922&txtFormat=html

Title: relative to accreditation of health care providers by pharmacy benefit managers.

Summary: This bill prohibits certain practices of pharmacy benefit managers except under certain circumstances until June 30, 2020.

2018 HB 1822 (Chapter 205)
http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2018&id=2046&txtFormat=html

Title: making hormonal contraceptives available directly from pharmacists by means of a standing order.

Summary: This bill allows pharmacists to dispense hormonal contraceptives pursuant to a standing order entered into by health care providers. This bill is the result of the commission established pursuant to 2017, 23.

Appendix C

NCSL

Prescription Drug Resource Center

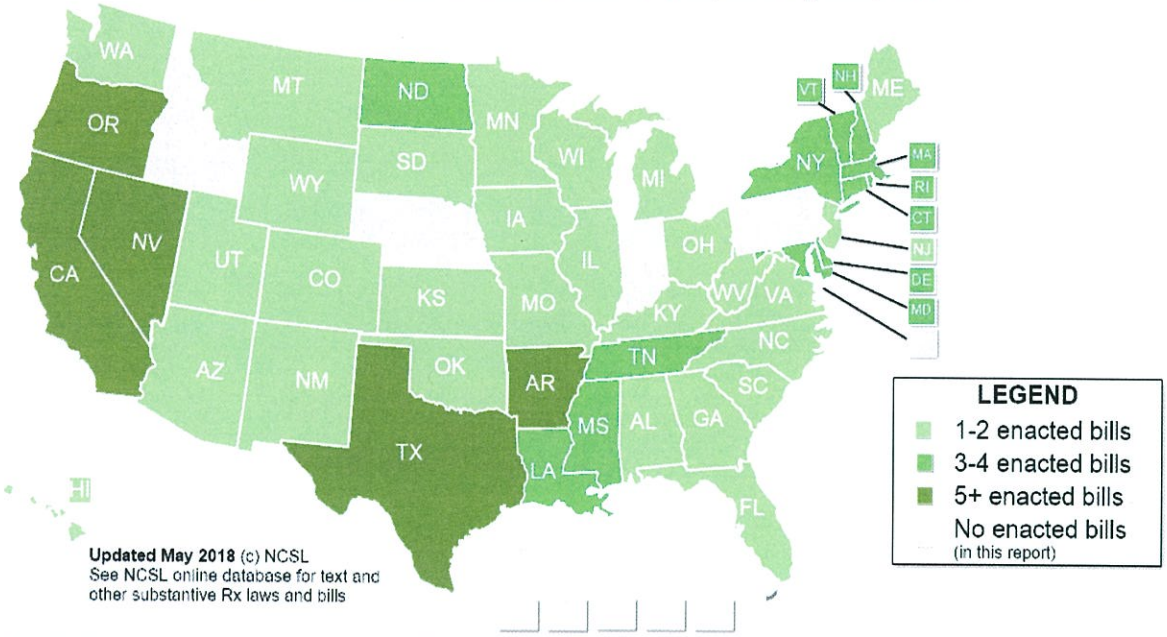
NATIONAL CONFERENCE of STATE LEGISLATURES

Recently Enacted State Laws Affecting Pharmaceutical Costs, Pricing and Payment 2015-2017

- Prescription drug transactions in the United States make up 10 percent of total health spending.
- State Legislatures consider an average of 1,000 measures each year that would affect pharmaceuticals
- State policymakers can use this guide to inform future decisions or compare state with federal activity.

U.S. Map of

Recent Pharmaceutical Laws Affecting Costs, Pricing and Payment, 2015-17



Map depicts all 50 U.S. states, territories, and the District of Columbia by number of bills relating to the costs, pricing and payment of pharmaceuticals.

May 2018
NCSL Health Program

Authors: Richard Cauchi, program director; Colleen Becker, policy specialist; Charles Severance-Medaris, policy associate

Introduction

For the past three years (2015-2017) there has been increased interest and activity on legislation that relates to the pricing, payment and costs associated with prescription drugs. Because of this legislative interest, states have enacted a diverse set of policy initiatives, including this selection of enacted legislation with a total of 119 signed bills from 45 states.[1]

Of the measures included in this report, some seek to reduce overall costs or prices of prescription drugs while others may shift costs from patients or payers to other entities. The legislation contained in this report represents a wide variety of approaches in a diverse mix of states and is intended to give the reader a comprehensive of overview of all the approaches taken by states over the last few years to address costs, pricing and payment of pharmaceutical drugs with attention to the specific measures taken by different states facing different challenges and healthcare landscapes.

In terms of broad topics, legislation addressing "coverage in insurance" has seen the most legislative attention, with 29 states enacting one or more bills affecting the coverage requirements and restrictions for commercial and ACA[2] exchange insurers. Other topics, like pharmacy benefit managers (PBMs) and transparency issues, such as "gag clauses," have seen heightened attention from legislators more recently as national media outlets have scrutinized these aspects of the healthcare systems.

This report is based on enacted legislation excerpted from the NCSL Prescription Drug Online Database.[3] The complete NCSL directory details 682 enacted laws and resolutions from all 50 states, D.C. and Puerto Rico. Entries to this report are listed alphabetically by state and chronologically by year for each state. A reference table of included topics listing which states have enacted relevant legislation is provided below.

A detailed **index of topics** is included at the end of this document.

Legislation by Topic and State

Access	Cost Sharing & Deductibles	Coverage in Insurance	Medicaid Pharm. Use & Cost	Pricing & Payment	Pharm. Utilization & Management	PBMs	Transparency & Disclosure
20	20	31	21	15	21	18	11

Access- State policies that affect the way in which patients obtain prescription drugs, including their availability through public or private health facilities or medical providers and pharmacies.

> Arizona, Arkansas, California, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, West Virginia, Wyoming

Cost Sharing and Deductibles- Includes consumer-related pricing policies such as tiers, copayments, deductibles, out-of-pocket limits (OOP), discount coupons, insurance reference prices and price disclosures.

> Arkansas, California, Colorado, Connecticut, Delaware, Illinois, Louisiana, Maryland, Nevada, New Hampshire, New Mexico, North Dakota, Oklahoma, Rhode Island, South Dakota, Texas, Utah, Washington, West Virginia, Wyoming

[1] **This search is based on the following filters: Topics:** Cost Sharing and Deductibles; Pharmaceutical Pricing and Payment; Rx Medicaid Use and Cost; Pharmacy Benefit Managers.
[2] **ACA**: The Patient Protection and Affordable Care Act, also termed ACA, PPACA and "Obamacare" in state legislative documents.
[3] **The NCSL database is live online at** http://www.ncsl.org/research/health/prescription-drug-statenet-database.asp.

Coverage in Insurance- Includes requirements and restrictions affecting commercial and ACA exchange or market-place-related insurance. Includes state mandates, parity or essential health benefit laws specific to prescription drugs.

Arkansas, California, Connecticut, Delaware, Hawaii, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Missouri, Montana, Nevada, New Hampshire, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming

Medicaid Pharmaceutical Use and Cost- Medicaid use of coverage and cost strategies, including preferred drug lists (PDLs), supplemental rebates, utilization review, prior authorization, Pharmacy & Therapeutics (P & T) committees and related policies.

Alabama, Arkansas, California, Hawaii, Louisiana, Massachusetts, Mississippi, Montana, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, South Carolina, Tennessee, Texas, Vermont, Wisconsin

Pharmaceutical Pricing and Payment- Includes state-required or state-authorized manufacturer rebates, discounts, generic and brand name drug choice, carve-outs, transparency and reimbursement formulas. Also includes regulation of formularies.

Arkansas, California, Connecticut, Florida, Georgia, Illinois, Louisiana, Massachusetts, Montana, Nevada, New Hampshire, Oregon, Tennessee, Texas, Vermont

Pharmaceutical Utilization Management- Includes use of commercial insurance and retail formularies, preferred drug lists (PDLs), prior authorization, utilization review, "fail first" state and commercial programs, fill limits and other requirements or incentive programs.

Arkansas, California, Colorado, Hawaii, Iowa, Kansas, Louisiana, Massachusetts, Montana, Nevada, New Hampshire, New Mexico, New York, North Dakota, Ohio, Oregon, Tennessee, Texas, Virginia, West Virginia, Wyoming

Pharmacy Benefit Managers (PBM)- State policies affecting transparency of PBMs, maximum allowable cost (MAC) lists and PBM/provider disclosure. Also, includes measures to eliminate or restrict 'clawbacks' and 'gag-clauses' and to reform audit standards and certain contractual provisions between pharmacies and PBMs, including 'price-gouging.'

Arkansas, Connecticut, Delaware, Georgia, Iowa, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nevada, North Dakota, Rhode Island, South Carolina, Tennessee, Virginia, Wyoming

Prohibit "Gag Clauses": Arkansas, Connecticut, Georgia, Louisiana, Maine, Mississippi, Nevada, North Dakota

Transparency and Disclosure- State policies requiring transparency and disclosure on the part of PBMs, pharmacies, medical practitioners, and manufactures relating to costs and pricing of pharmaceutical drugs.

Arkansas, Connecticut, Florida, Georgia, Louisiana, Maine, Missouri, Montana, South Dakota, Texas, Vermont

Americans for Disability Act (ADA) - Compliant List of Legislation:
The enacted legislation listed in this full publication is online within the NCSL database at
http://www.ncsl.org/Default.aspx?TabId=28729

To retrieve the laws, including links to full text:

1) ***Select states as "All"***
2) ***Select topics as:***
   - *Cost Sharing and Deductibles -Consumers*
   - *Medicaid Use and Cost - Rx Drugs*
   - *Pricing and Payment – Industry*
   - *Pharmacy Benefit Managers*
3) ***Select Year as "All"*** *(includes 2015-2018)*
4) ***Select Status as "Enacted" or "Adopted"***

Topics beyond cost, pricing, access and payment are tracked and reported by NCSL onine. Those topics include:

- Biologics and Biosimilars
- Clinical Trials and Right to Try
- Compounding Pharmacy Regulation
- Insurance/Coverage - Rx Drugs
- Safety and Errors - Rx Drugs
- Specialty Pharmaceuticals
- Utilization Management - Rx Drugs
- Other Prescription Drug Measures

This report does not include: enacted bills concerning the routine regulation of pharmacies or their staff, illegal drugs, medical or recreational marijuana or over-the-counter (OTC) medication except where such products are treated as covered benefits.

The NCSL Prescription Drug Policy Resource Center is supported in part by a grant from the Laura and John Arnold Foundation, for research and educational resources conducted November 2017-2019. Editorial content is the sole responsibility of NCSL.

Enacted Bill Information	Summary
ALABAMA	
AL H 8 | 2015 **Privilege Tax Upon Providers of Pharmaceutical Services** **Last Action:** 09/17/2015 - Enacted - Act No. 2015-537 **Author:** Beech (D) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Medicaid Use & Cost	Provides a specified state ''supplemental privilege tax'' (or provider tax) for each prescription filled or refilled, to be collected on the business activities of every provider of pharmaceutical services to the citizens of Alabama, except for a pharmacy serving hospital in-patients or pharmacies operated by the State of Alabama, for collection in fiscal years 2016 and 2017. The ''revenue generated from this tax will be eligible for Federal Medicaid matching funds (FMAP), being that portion of funds paid by the federal government to the State of Alabama for providing and administering the State's Medicaid Program. The tax would be void if it is not eligible for such matching funds.
ARIZONA	
AZ H 2382 | 2017 **Free Speech in Medicine Act** **Last Action:** 03/21/2017 - Enacted - Act No. 41 **Author:** Lovas (R) **Topics:** Access & Cost Sharing,	Creates a “Free Speech in Medicing Act.” Allows drug makers to promote and market drugs off-label if the information consists of “truthful promotion” of a drug, biological product or device. Prohibits the state or any medical board or subdivision from enforcing any federal or state restriction on manufacturers, health care institutions or a physician from such “truthful promotion.” Does not require a health care insurer, other third-party payer or other health plan sponor to provide coverage for the cost of any off-label use of a drug, biological product or device as a treatment. The law conflicts with current federal law, 21 USC Sec. 331, restricting drug manufacturuers from promoting off-label uses.
ARKANSAS	
AR S 101 | 2015 **DHS Division of Medical Services** **Last Action:** 02/06/2015 - Enacted - Act No. 41 **Author:** Joint Budget **Topics:** Pharmaceutical Pricing & Payment - Industry	2015-2016 state budget provides that ''the State shall conduct an independent survey utilizing generally accepted accounting principles, to determine the cost of dispensing a prescription by pharmacists in Arkansas. Only factors relative to the cost of dispensing shall be surveyed. These factors shall not include actual acquisition costs or average profit or any combination of actual acquisition costs or average profit.''
AR S 318 | 2015 **Prior Authorization Transparency Act** **Last Action:** 04/06/2015 - Enacted - Act No. 1106 **Author:** Irvin (R) **Topics:** Access & Cost Sharing, Rx Utilization Management, Rx Medicaid Use & Cost, Rx Coverage in Insurance	Ensures transparency in use of prior authorizations for medical treatment. Requires a goal to "Ensure that prior authorizations do not hinder patient care or intrude on the practice of medicine, and guarantee that prior authorizations include the use of written clinical criteria and reviews by appropriate physicians to secure a fair authorization review process for patients."

Enacted Bill Information	Summary
AR S 466 | 2015 **Drug Formulary Information in Benefit Plan** **Last Action:** 04/06/2015 - Enacted - Act No. 1109 **Author:** Irvin (R) **Topics:** Access & Cost Sharing, Rx Utilization Management, Rx Coverage in Insurance, Cost Sharing & Deductibles	Requires health benefit plans to disclose drug formulary information. Health benefit plans, issued or renewed in Arkansas shall post on the public part of its website "all of its drug formulary costs, benefits, and expenses for coverage for a prescription drug in clear and ordinary terms."
AR S 688 | 2015 **Pharmacy Maximum Allowable Cost Lists** **Last Action:** 04/01/2015 - Enacted - Act No. 900 **Author:** Caldwell (R) **Topics:** Pharmaceutical Pricing & Payment- Industry, Pharmacy Benefits Manager	Requires pharmacy benefits managers to update their maximum allowable cost list within seven days of a cost increase and requires pharmacy benefits managers to create an appeal process by which a pharmacy can challenge a maximum allowable cost for a specific drug or drugs.
AR H 1453 | 2015 **State Kidney Disease Commission** **Last Action:** 04/04/2015 - Enacted - Act No. 1029 **Author:** Miller (R) **Topics:** Access & Cost Sharing, Cost Sharing & Deductibles	Establishes a program to assist persons suffering from acute or chronic renal failure in obtaining care and treatment requiring kidney dialysis or transplantation, provides that services to assist persons requiring transplantation may include the copayment of immunosuppressant drugs post-transplantation.
CALIFORNIA	
CA A 1048 | 2017 **Health Care: Pain Management & Schedule II Drug Rx** **Last Action:** 10/09/2017 - Enacted - Act No. 2017-615 **Author:** Arambula (D) **Topics:** Rx Coverage in Insurance, Cost Sharing & Deductibles	Authorizes a pharmacist to dispense a Schedule II controlled substance as a partial fill if requested by a patient or the prescriber. Authorizes a pharmacist to charge a dispensing fee to cover the actual supply and labor costs. Requires a health care insurer to prorate an insured's cost sharing for a partial fill prescription of an oral, solid dosage form prescription drug.
CA S 17 | 2017 **Health Care: Prescription Drug Costs** **Date of Last Action:** 10/09/2017 - Enacted - Act No. 2017-603 **Author:** Hernández (D) **Additional Authors:** Chiu (D); Wood (D) **Topics:** Pharmaceutical Pricing & Payment - Industry	Requires pharmaceutical manufacturers to submit to public and private purchasers (including state agencies, health insurers, and pharmacy benefit managers) 90-day advance notification of price increases for prescription drugs currently on the market, including detailed information regarding the reasons and justification for such increases, as well as justification of launch prices for new drugs. Requires health insurers that file rate information to report specified cost information regarding covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs. Requires reporting the percentage of the insurance premium attributable to prescription drugs.

Enacted Bill Information	Summary
CA A 265 | 2017 **Prescription Drugs: Prohibition on Price Discount** **Last Action:** 10/09/2017 - Enacted - Act No. 2017-611 **Author:** Wood (D) **Additional Authors:** Chiu (D) **Topics:** Pharmaceutical Pricing & Payment - Industry, Cost Sharing & Deductibles	Prohibits a person who manufactures a prescription drug from offering any discount coupon, repayment, product voucher, or other reduction in an individual's out-of-pocket expenses, including a copayment, coinsurance, or deductible, for any prescription drug if a lower cost generic drug is covered under the individual's health insurance, health care service plan, or other health coverage on a lower cost-sharing. Specifies exceptions to these prohibitions if the individual has completed any applicable step therapy and does not regulate "a pharmaceutical product free of any cost, if the product is free of cost to both the patient and his or her health insurer, health care service plan, or other health coverage."
CA A 339 - 2015 **Health Care Coverage: Outpatient Prescription Drugs** **Last Action:** 10/08/2015 - Enacted - Act No. 619 **Author:** Gordon (D) **Additional Authors:** Atkins (D) **Topics:** Access & Cost Sharing, Rx Utilization Management, Cost Sharing & Deductibles	Provides that the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription shall not exceed $250 for a supply of up to 30 days, when purchased through an individual or small employer health policy (Effective Jan. 1, 2017; the operational law affects about 134,000 residents.) Also requires coverage of a single pill combination antiretroviral drug treatment needed to treat AIDS/HIV. Also requires uniform definitions of four copayment tiers if used in a health insurance formulary. When an insured is changing policies, prohibits a new insurer from requiring the insured to repeat step therapy when that person is already being treated for a medical condition by a specific prescription drug.
CA A 1696 | 2016 **Medi-Cal: Tobacco Cessation Services** **Last Action:** 09/25/2016 - Enacted - Act No. 606 **Author:** Holden (D) **Additional Authors:** Wood (D) **Topics:** Rx Medicaid Use & Cost, Cost Sharing & Deductibles	Provides that tobacco cessation services are covered benefits, subject to utilization controls, under the Medi-Cal program. Requires such services to include all intervention recommendations, as periodically updated, assigned a specified grade by the U.S. Preventive Services Task Force, and include quit attempts based upon medical necessity. Includes approved medication.
CA A 339 | 2015 **Health Care Coverage: Outpatient Prescription Drugs** **Date of Last Action:** 10/08/2015 - Enacted - Act No. 619 **Author:** Gordon (D) **Additional Authors:** Atkins (D) **Topics:** Access & Cost Sharing, Rx Utilization Management, Cost Sharing & Deductibles	Prohibits health care service plan or health care insurance formularies from discouraging the enrollment of individuals with health conditions and reducing the generosity of the benefit for those with a particular medical condition. Provides that a drug copay shall not exceed a specified amount for a specified supply. Provides an exception. Requires coverage of a single antiretroviral drug treatment needed to treat AIDS/HIV. Relates to coverage for medically necessary drugs. Relates to nonformulary drug requests.
COLORADO	
CO S 203 | 2017 **Alternative Drug Requirement** **Last Action:** 06/02/2017 - Enacted - Act No. 296 **Author:** Todd (D) **Additional Authors:** Covarrubias (R); Kennedy (D) **Topics:** Rx Utilization Management, Cost Sharing & Deductibles	Amends the prohibition against a carrier requiring a covered person to undergo step therapy, and, in connection therewith, requiring coverage for a prescribed medication that is part of the carrier's medication formulary.

Enacted Bill Information	Summary
CONNECTICUT	
CT S 445 | 2017 **Pharmacy Benefits Manager & Records** **Last Action:** 07/10/2017 - Enacted - Act No. 17-241 **Author:** Looney (D) **Additional Authors:** Fasano (R); Camillo (R); Elliott (D); Storms (R); Logan (R); Borer (D) **Topics:** Pharmaceutical Pricing & Payment- Industry, Pharmacy Benefits Manager	Would prohibit future legislation preventing pharmacists from disclosing specified information to an individual purchasing a drug (i.e. the availability of any alternative less expensive medications). Would prohibit a health carrier or PBM from requiring an individual to pay for a covered prescription in an amount greater than the lesser of the applicable copayment, (2) allowable claim amount (i.e. the amount the health carrier or PBM agreed to pay the pharmacy), or (3) amount an individual would pay for the drug if he or she had no insurance plan, benefits, or discounts. Authorizes the insurance commissioner to audit pharmacy services' contracts for compliance and to enforce violations by voiding contracts that contain unfair trade practices.
CT S 309 | 2016 **Prescription Drugs Pricing Study** **Status:** Enacted - Act No. 16-18 **Last Action:** 06/10/2016 - Enacted - Act No. 16-18 **Author:** Joint General Law **Additional Authors:** Looney (D) **Topics:** Pharmaceutical Pricing & Payment - Industry	Establishes a task force to study value-based pricing of prescription drugs, requires a report to the joint standing committees having cognizance of matters relating to consumer protection, insurance and public health.
CT S 811 | 2015 **Hospitals & Insurers- Pharmaceutical Transparency** **Last Action:** 06/30/2015 - Enacted - Act No. 15-146 **Author:** Looney (D) **Additional Authors:** Looney (D); Fasano (R); Hewett (D); Santiago H (D) **Topics:** Pharmaceutical Pricing & Payment - Industry, Access & Cost Sharing, Rx Coverage in Insurance, Cost Sharing & Deductibles	Requires health insurers, including on Exchange, to ''make available to consumers, in an easily readable and understandable format (A) Any coverage exclusions, (B) any restrictions on the use or quantity of a covered benefit, including on prescription drugs or drugs administered in a physician's office or a clinic, (C) a specific description of how prescription drugs are included or excluded from any applicable deductible, including other out-of-pocket expenses that apply to such drugs, and (D) the specific dollar amount of any copayment and the percentage of any coinsurance, including each covered prescription drug, (2) Make available to consumers (A) whether a specific prescription drug is available under such policy's drug formulary, (B) the coinsurance, copayment, deductible or other out-of-pocket expense applicable to such drug, (C) whether such drug is covered when dispensed by a physician or a clinic, (D) whether such drug requires preauthorization or the use of step therapy.

Enacted Bill Information	Summary
DELAWARE	
DE H 275 | 2017 **Appropriations Act – Repeal subsidized SPAP** **Last Action:** 07/03/2017 - Enacted - Act No. 58 **Author:** Smith (D) **Additional Authors:** Ennis (D); McDowell (D); Johnson J (D); Carson (D); Ramone (R); Bushwalker (D); Heffernan (D); Kenton (R); Pore (D) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Coverage in Insurance, Cost Sharing & Deductibles	Amends the Fiscal Year 2018 Appropriation Act, repeals the Prescription Drug Payment Assistance Program (SPAP) which subsidized certain Medicare Part D costs to Delaware's low-income senior and disabled citizens who are ineligible for other coverage.
DE H 284 | 2016 **Pharmacy Benefit Managers** **Last Action:** 05/25/2016 - Enacted - Act No. 245 **Author:** Short B (D) **Additional Authors:** Henry (D);Cloutier (R);Kowalko (D);Baumbach (D);Gray (R);Potter (D) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Coverage in Insurance, Pharmacy Benefit Managers	Provides for the establishment of the Pharmacy Audit Integrity Program related to pharmacy benefit managers (PBMs). Requires the use of legal prescriptions to validate specified claims, applicability to investigative audits involving fraud or abuse, requirements for maximum allowable cost pricing for prescription drugs and the establishment of a process by which a contracted pharmacy can appeal the provider's reimbursement for a drug subject to maximum allowable cost pricing.
DE H 38 | 2015 **Pharmacy Audits (PBMs)** **Status:** Enacted - Act No. 65 **Date of Last Action:** 06/30/2015 - Enacted - Act No. 65 **Author:** Keeley (D) **Topics:** Pharmacy Benefit Managers	Specifies procedures that must be followed during PBM pharmacy audits, provides standards, requires notification prior to modifying audit terms between pharmacy benefit managers and pharmacies, provides that auditors may not enter the pharmacy area unless escorted where patient-specific information is available and to the extent possible must be out of sight and hearing range of the pharmacy customers.
FLORIDA	
FL H 589 | 2017 **Prescription Drug Price Transparency** **Date of Last Action:** 06/09/2017 - Enacted - Act No. 2017-86 **Author:** Yarborough (R) **Additional Authors:** Magar (R);Renner (R);Baez (D);White (R) **Topics:** Pharmaceutical Pricing & Payment - Industry	Requires the Agency for Health Care Administration to collect data on retail prices charged by pharmacies for the most frequently prescribed medicines, requires the agency to update its website monthly.

Enacted Bill Information	Summary
GEORGIA	
GA S 103 & H 276 | 2017 **Pharmacy Benefits Managers** **Date of Last Action:** 05/08/2017 - Enacted - Act No. 196 & 195 **Author:** Mullis (R) **Additional Authors:** Ginn (R);Beach (R) **Topics:** Pharmacy Benefits Managers	Authorizes the Commissioner of Insurance to promulgate certain rules and regulations and to examine and investigate certain matters with regard to pharmacy benefits managers, prohibits pharmacy benefits managers from requiring the use of mail-order pharmacies under certain conditions, prohibits a pharmacy benefits manager from penalizing disclosure of information on costs shares and more affordable alternatives.
GA H 470 | 2015 **Pharmacies & PBMs** **Status:** Enacted - Act No. 61 **Last Action:** 05/05/2015 - Enacted - Act No. 61 **Author:** Knight (R) **Additional Authors:** Carter A (R);Shaw J (R) **Topics:** Pharmaceutical Pricing & Payment - Industry	Changes certain provisions relating to The Pharmacy Audit Bill of Rights, relates to regulation and licensure of pharmacy benefits managers, so as to define certain terms, imposes certain requirements for the use of maximum allowable cost pricing by pharmacy benefits managers, provides for enforcement of such requirements, repeals conflicting laws.
HAWAII	
HI H 1444 | 2017 **Pharmacy Benefit Managers** **Date of Last Action:** 06/20/2017 - Enacted - Act No. 44 **Author:** Morikawa (D) **Additional Authors:** Oshiro M (D);Belatti (D);McKelvey (D);Kobayashi (D) **Topics:** Insurance/Coverage - Rx Drugs	Requires pharmacy benefit managers to register with the Insurance Commissioner to provide transparency and ensure adequate consumer protection.
HI S 2392 | 2016 **Opioid Antagonists- Medicaid coverage** **Last Action:** 06/16/2016 - Enacted - Act No. 68 **Author:** Baker (D) **Additional Authors:** Chun Oakl& (D);Keith-Agaran (D);Kidani (D);Galuteria (D);Gabbard (D);Green (D);Shimabukuro (D);English (D);Inouye (D);Ruderman (D) **Topics:** Rx Medicaid Use & Cost	Requires Medicaid coverage for opioid antagonists, and provides immunity to prescribers of opioid antagonists.
HI S 1106 | 2015 **Medicaid Managed Care Program** **Last Action:** 04/23/2015 - Enacted - Act No. 2015-20 **Author:** Kim (D) **Topics:** Rx Utilization Management, Rx Medicaid Use & Cost	Authorizes all Medicaid managed care health plans to subject prescription drugs for specific conditions (covered in section 346-352, Hawaii Revised Statutes), to prior authorization procedures.

Enacted Bill Information	Summary
ILLINOIS	
IL H 2531 | 2017 **Generic Drug Product Substitution** **Last Action:** 08/11/2017 - Enacted - Act No. 65 **Author:** Hammond (R) **Additional Authors:** Bellock (R);Tracy (R) **Topics:** Pharmaceutical Pricing & Payment - Industry	Amends the Food, Drug and Cosmetic Act, deletes provisions requiring manufacturers to provide the Director of Public Health with a notification containing product technical bioequivalence information no later than a certain number of days prior to specified generic drug product substitution. Allows the interchange of different brands of the same generically equivalent drug product provided that the same dosage form is dispensed and there is no greater than 1% variance in the stated amount of each active ingredient of the drug products.
IL H 2957 | 2017 **Insurance Code** **Last Action:** 08/18/2017 - Enacted - Act No. 138 **Author:** Fine (D) **Additional Authors:** Mulroe (D);Murphy L (D) **Topics:** Rx Coverage in Insurance, Cost Sharing & Deductibles	Amends the Insurance Code, provides that every policy of accident and health insurance amended, delivered, issued, or renewed after the effective date of the amendatory Act that provides coverage for prescription drugs shall provide for synchronization of prescription drug refills on at least one occasion per insured per year provided that certain conditions are met, requires insurers to provide prorated daily cost-sharing rates when necessary.
IOWA	
IA H 233 | 2017 **Step Therapy Protocols** **Last Action:** 05/10/2017 - Enacted **Author:** Human Resources Cmt **Topics:** Rx Utilization Management; Rx Coverage in Insurance	Provides for a step therapy override exception process. When the coverage of a prescription drug is restricted by a health insurance plan or utilization review organization due to a step therapy (or fail-first) protocol, the patient shall have access to a clear process to request a step therapy override exception, allowing access to a medically necessary higher cost drug. Insurance plans can use their existing medical exceptions process to satisfy this requirement.
IA H 395 | 2015 **Regulation of Pharmacy Benefits Managers** **Last Action:** 04/02/2015 - Enacted - Act No. 24 **Author:** Commerce Cmt **Topics:** Pharmacy Benefits Managers	Provides that after notice and hearing, the commissioner of insurance may impose sanctions and may suspend or revoke a pharmacy benefits manager's certificate of registration as a third-party administrator, provides that a pharmacy benefits manager is subject to the commissioner's authority to conduct examinations, audits and inspections, provides for confidentiality of records.
KANSAS	
KS S 103 | 2016 **Pharmacy Benefits Managers** **Last Action:** 03/23/2016 - Enacted - Act No. 2016-13 **Author:** Financial Institutions & Insurance Cmt **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Utilization Management, Pharmacy Benefits Managers	Establishes pharmacy benefits managers (PBMs) limitations on activities, related to use of "maximum allowable cost" price lists, meaning the maximum amount that a pharmacy benefits manager will reimburse a pharmacy for the cost of a generic drug. Provides appeal rights for in-network pharmacies.

Enacted Bill Information	Summary
KS H 2135 | 2015 **Appropriations (Increasing Access with 340B Subsidies)** **Last Action:** 06/16/2015 - Enacted - Act No. 2015-103 **Author:** Joint Special Claims Against the State **Topics:** Pharmaceutical Pricing & Payment - Industry, Access & Cost Sharing	Increasing "access to prescription drugs by subsidizing a portion of the costs for the benefit of patients at section 340B participating clinics on a sliding fee scale" and expanding access to prescription medication assistance programs by making expenditures to support operating costs.
KENTUCKY	
KY H 377 | 2015 **Pharmacist & Practitioner Collaborative Agreement** **Last Action:** 04/03/2015 - Enacted - Act No. 118 **Author:** Schamore (D) **Additional Authors:** Westrom (D);Harris (D);Rowl& (R);Stone (D);Belcher Li (D);Santoro (R);Greer (D);Wuchner (R);Thompson (D);Horl&er (D);Marzian (D);DeWeese (R);Howard (D) **Topics:** Access & Cost Sharing	Permits a collaborative agreement to be made between more than one pharmacist and practitioner for the cooperative management of a patient's drug-related health care needs.
LOUISIANA	
LA S 59 | 2017 **Health Care- drug price information** **Last Action:** 06/14/2017 - Enacted - Act No. 236 **Author:** Mills (R) **Additional Authors:** Johns (R);Morrish (R) **Topics:** Pharmaceutical Pricing & Payment - Industry	Mandates the Louisiana Board of Pharmacy to develop a website containing specified prescription drug pricing information to be made available to Louisiana prescribers on the board's website with a dedicated link that is prominently displayed or with a distinctive web name. The site can be used by pharmaceutical marketers to inform prescribers of products to treat a particular condition. Provides for grant funding opportunities.
LA H 436 | 2017 **Drugs & Prescription prices** **Last Action:** 06/14/2017 - Enacted - Act No. 220 **Author:** Talbot (R) **Additional Authors:** LeBas (D);Thibaut (D);Moreno (D);Hollis (R);Miller D (D) **Topics:** Pharmaceutical Pricing & Payment - Industry	Requires drug manufacturers to provide transparency of information regarding prescription drug prices. Each manufacturer or pharmaceutical marketer ''who engages in any form of prescription drug marketing'' to a physician, prescriber or any member of his or her staff in Louisiana to provide to the Louisiana Board of Pharmacy the current WAC (wholesale acquisition cost) information for each of the U.S. FDA approved drugs marketed in the state by that manufacturer.
LA HR 181 | 2017 **Drugs and Prescription** **Last Action:** 06/05/2017 - Enacted **Author:** Talbot (R) **Topics:** Pricing and Payment - Industry, Medicaid Use and Cost - Rx Drugs	Non-binding House resolution, urges and requests the Louisiana Department of Health to study the desirability and feasibility of adopting state policy to provide for review of prescription drug prices in the medical assistance program, including to provide supplemental Medicaid rebates. References similar recently enacted policies of the states of New York, Texas, and Ohio.

Enacted Bill Information	Summary
LA H 864 | 2016 **Pharmacy Claims Fees** **Last Action:** 05/19/2016 - Enacted - Act No. 148 **Author:** LeBas (D) **Topics:** Access & Cost Sharing, Rx Utilization Management, Rx Coverage in Insurance, Cost Sharing & Deductibles, Pharmacy Benefit Managers	Prohibits health insurance issuers and pharmacy benefit managers from assessing certain pharmacy claims fees.
LA H 568 | 2015 **Board of Pharmacy & Prohibited Acts** **Last Action:** 07/01/2015 - Enacted - Act No. 409 **Author:** Thierry (D) **Topics:** Pharmaceutical Pricing & Payment - Industry	Requires the production of information necessary for the investigation of violations, prohibits the use of an independent contractor to provide marketing services for compensation unless the compensation is not based on the volume or value of prescriptions filled by the pharmacy, prohibits dispensing any drug or device if the practitioner or a member of the practitioner's group has a financial or relationship with the distributing pharmacy.
MAINE	
ME S 10 | 2017 **Clean Claims Submitted by Pharmacies** **Last Action** 05/05/2017 Enacted, - Act No. 44 **Author:** Gratwick (D) **Additional Authors:** Dill J (D);Katz (R);Foley (R);Tucker (D);Cyrway (R);Deschambault (D);Sylvester (D);Carpenter (D) Topics: Gag Clauses, Pharmacy Benefit Mangers	Prohibits a health insurance carrier or pharmacy benefits manager from imposing on an enrollee a copayment or other charge that exceeds the claim cost of a prescription drug, prohibits a carrier or pharmacy benefits manager (PBM) from penalizing a pharmacy provider for providing information ("gag clause") related to an enrollee's out-of-pocket cost or the clinical efficacy of a prescription drug or alternative medication. “If information related to an enrollee's out-of-pocket cost or the clinical efficacy of a prescription drug or alternative medication is available to a pharmacy provider, a carrier or pharmacy benefits manager may not penalize a pharmacy provider for providing that information to an enrollee.
ME H 788 | 2016 **Maximum Allowable Cost Pricing Lists** **Last Action:** 04/11/2016 - Enacted - Act No. 450 **Author:** Brooks (D) **Additional Authors:** Nutting R (R);Rotundo (D);Morrison (D);Beavers (D);Picchiotti (R);Katz (R);Whittemore (R);Beck (D);Prescott D (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Utilization Management, Pharmacy Benefit Managers	Establishes requirements for maximum allowable cost (MAC) pricing lists used by pharmacy benefits managers and requires pharmacy benefits managers (PBMs) to make disclosures regarding that pricing and the methods used to establish that pricing to plan sponsors. It establishes an appeal process for pharmacies for disputes relating to maximum allowable cost pricing. The bill also provides for financial penalties for violations.

Enacted Bill Information	Summary
LD 1150 & HP 788 | 2016 **An Act Regarding Maximum Allowable Cost Pricing Lists Used by Pharmacy Benefit Managers** **Last Action:** 3/31/2016 - Enacted – Chapter 450 **Author:** Brooks **Topics:** Insurance/Coverage - Rx Drugs, PBMs	Requires Rx cost disclosure by PBMs to plan sponsors of Maximum Allowable Cost Pricing Lists.
ME S 229 | 2015 **Health Care Costs Transparency** **Status:** Enacted - Vetoed by Governor **Date of Last Action:** 06/23/2015 Enacted-Veto Overridden **Author:** Dill J (D) **Topics:** Access & Cost Sharing	Requires all health insurance carriers offering individual and group health plans to provide certain information with respect to prescription drug coverage to prospective enrollees and enrollees on its publicly accessible website, requires carriers to post each prescription drug formulary for each plan in a manner that allows enrollees to determine whether a particular prescription drug is covered under a formulary. Requires providing information about utilization review, cost-sharing, and exclusions.
MARYLAND	
MD H 631 & S 415 | 2017 **Essential Generic Drugs** **Last Action:** 05/27/2017 - Enacted - Act No. 818 **Author:** Busch (D) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Coverage in Insurance, Cost Sharing & Deductibles	Prohibits a manufacturer or wholesale distributor from engaging in price gouging in the sale of an essential off-patent or generic drug, establishes that it is not a violation of a certain provision of this Act for a wholesale distributor to increase a price of an essential off-patent or generic drug under certain circumstances, requires a manufacturer of an essential off-patent or generic drug to submit a certain statement to the Attorney General within a certain time frame.
MD S 848 & MD H 1005 | 2016 **Health Insurance Contraceptive Equity Act** **Last Action:** 05/10/2016 - Enacted - Act Nos. 436 & 437 **Senate Author:** Kelley **House Author:** Kelly A (D) **Topics:** Access & Cost Sharing, Rx Coverage in Insurance, Cost Sharing & Deductibles	Prohibits certain entities from applying prior authorization requirements for certain contraceptive drugs or devices, requires coverage for male sterilization and single dispensations of prescription contraceptives for certain period of time, provides for concurrent increases in copayments and dispensing fees, point of sale coverage, coverage frequency limits, off-formulary prescriptions, requires coverage without a prescription and prohibits application of copayments under certain conditions.
MD H 613 | 2015 **Hospital Services- 340B** **Last Action:** 05/12/2015 - Enacted - Act No. 263 **Author:** Hammen (D) **Topics:** Pharmaceutical Pricing & Payment - Industry, Access & Cost Sharing	Allows including a hospital outpatient service that meets criteria for the purpose of making it possible for the hospital outpatient service to participate in the 340B prescription drug discount federal program under rates set by the State Health Services Cost Review Commission.

Enacted Bill Information	Summary
MASSACHUSETTS	
MA H 3800 | 2018 **Fiscal Year 2018 Budget Bill- bulk Rx purchasing** **Last Action:** 07/17/2017 - Line Item Vetoed **Author:** Report of Conference Committee **Topics:** Pharmaceutical Pricing & Payment - Industry	The FY 2018 state budget appropriates $47,835,000 for the costs of pharmaceutical drugs and services provided by the State Office for Pharmacy Services, in this item called SOPS, supplying Public Health, Mental Health, developmental health as well as corrections, 10 county prisons and other local entities. For the costs of pharmaceutical drugs and services provided by the state office for pharmacy services, in line item 4510-0108, with other vendors excluded. Also ''administration of the subsidized catastrophic prescription drug insurance program under section 39 of chapter 19A shall be the payer of last resort for this program for eligible persons.
MA H 4009 | 2018 **Contraceptive Insurance Coverage** **Last Action:** 11/20/2017 - Enacted - Act No. 120-2017 **Author:** Joint Financial Services **Topics:** Rx Medicaid Use & Cost, Rx Coverage in Insurance	Amends the General Laws, mandates insurance coverage of an expanded range of contraceptive services and methods.
MA H 3650 | 2015 **General Appropriations for Fiscal Year 2016- Prescription Drugs** **Last Action:** 07/17/2015 - Signed with Line Item Vetoes **Author:** Report of Conference Committee **Topics:** Access & Cost Sharing, Rx Utilization Management, Rx Medicaid Use & Cost	Appropriates $500,000 for the operation of an evidence-based outreach and education program designed to provide information and education on the therapeutic and cost-effective utilization of prescription drugs to physicians, pharmacists and other health care professionals authorized to prescribe and dispense prescription drugs. Reauthorizes funding for the state pharmaceutical assistance program (SPAP) with wrap-around benefits for qualified elders and disabled, as payor of last resort, with $18,668,169 appropriated. Requires that Medicaid ''shall investigate and provide a report on potential cost savings for prescription medications including the feasibility of joining a Medicaid multistate prescription drug bulk purchase consortium and pursuing new supplemental rebates from prescription drug manufacturers.
MICHIGAN	
MI S 502 | 2016 **Health Care False Claims Act** **Last Action:** 04/12/2016 - Enacted - Act No. 80 **Author:** Marleau (R) **Additional Authors:** Robertson (R);Jones Ri (R);Stamas J (R);Shirkey (R) **Topics:** Access & Cost Sharing	Modifies exemption to the Health Care False Claims Act, provides that a rebate, discount or similar payment from a drug manufacturer or from a company that licenses or distributes the drugs of a drug manufacturer to a consumer or other person on the consumer's behalf, for that consumer's use of a drug manufactured or licensed or distributed by that drug manufacturer or company or for health care items or services related to that use, does not violate the Act.

Enacted Bill Information	Summary
MINNESOTA	
MN H 2749 2016 **State Finances** **Status:** Enacted - Act No. 189 **Date of Last Action:*** 06/01/2016 - Enacted **Author:** Knoblach (R) **Additional Authors:** Nornes (R);Loon (R) **Topics:** Access & Cost Sharing; Biologics and Biosimilars, Access	In budget bill, inserts provisions for expedited consumer appeal of denial for coverage of a prescribed drug, also restricting use of step therapy; includes an exclusion that ''does not include a requirement for an enrollee to use a generic or biosimilar product considered by the FDA to be therapeutically equivalent and interchangeable to a branded product, provided the generic or biosimilar product has not previously been tried by the patient.'' Also ''the FDA Orange Book or a biologic drug rated as interchangeable according to the FDA Purple Book, at a lower cost to the enrollee, and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.''
MISSISSIPPI	
MS H 462 | 2016 **Pharmacy Practice Act Extend Repealer** **Action:** 04/20/2016 - Enacted **Author:** Mims (R) **Topics:** Pharmacy Benefit Managers	Extends the valid date on the State Pharmacy Practice Act, provides election procedures for Pharmacy Board member selection, provides that Board shall regulate the practice of pharmacy and pharmacy benefit managers (PBMs), specifies to license renewal fees, relates to regulation and registration fees for prescription drug distributors, relates to non-resident pharmacies, updates civil immunity provisions for pharmacies and their pharmacists.
MS H 545 | 2015 **Medicaid** **Status:** Enacted - Act No. 473 **Date of Last Action:** 04/23/2015 - Enacted - Act No. 473 **Author:** Howell (R) **Topics:** Rx Medicaid Use & Cost	Authorizes meetings of the pharmacy and therapeutics committee of the division of Medicaid, provides that any judicial appeal by a recipient or provider against the division shall be made within a certain number of days after notification, requires persons who provide Medicaid planning services for compensation to register, requires a list of registered planners, relates to a study of bariatric surgery on the morbidly obese, Medicaid planners and community mental health holding facilities.
MS H 456 | 2016 **Pharmacy** **Last Action:** 05/03/2016 - Enacted - Signed by Governor **Author:** Mims (R) **Topics:** Pharmacy Benefit Managers	Provides that a network pharmacy or pharmacist that has a contract with a pharmacy benefit manager to provide covered drugs at a negotiated reimbursement rate may decline to provide certain drugs or services if the network pays less than the acquisition cost for the product. “If the network pharmacy or pharmacist declines to provide such drug or service, the pharmacy or pharmacist shall provide the customer with adequate information as to where the prescription for the drug or service may be filled.” *(Variation on gag clause, with limited applicability)*
MS H 952 | 2015 **Anti Cancer Medications** **Last Action:** 04/23/2015 - Enacted - Act No. 490 **Author:** Busby (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Access & Cost Sharing	Prohibits health plans that cover injected, intravenously administered and oral anti-cancer medications from requiring a higher co-payment, deductible or coinsurance amount for patient administered medications than they require for medications injected or intravenously administered, directs the state and school employees health insurance management board to accept bids for surgical services that include a rate bundle and payment for orthopedic, spine, bariatric, cardiovascular and general surgeries.

Enacted Bill Information	Summary
MS S 2588 | 2015 **Medicaid Reimbursement** **Date of Last Action:** 04/22/2015 - Enacted - Act No. 483 **Author:** Kirby (R) **Topics:** Rx Medicaid Use & Cost	Authorizes waivers to reimburse for adult day care facilities services, provides for a hospital access program to provide additional inpatient reimbursements, authorizes a provider-sponsored health plan, provides that no health plan may override medical decisions of hospital physicians or staff regarding emergency room patients, relates to hospital assessments, relates to the normal rate of Medicaid reimbursement.
MISSOURI	
MO S 608 | 2016 **Healthnet & Health Care** **Date of Last Action:** 09/14/2016 - Enacted **Author:** Sater (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Access & Cost Sharing, Rx Coverage in Insurance, Pharmacy Benefit Managers	Modifies provisions relative the Health Care Cost Reduction and Transparency Act, palliative care, MO HealthNet co-payments or reimbursement, emergency supplies of medication, maintenance medication, medication synchronization, pharmacy benefit managers, insurance coverage for occupational therapy and cost transparency.
MO S 635 | 2016 **Health Care** **Last Action:** 07/05/2016 - Enacted **Author:** Hegeman (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Access & Cost Sharing, Pharmacy Benefit Managers	Establishes regulations on PBMs: a ''pharmacy benefits manager shall not place a drug on a maximum allowable cost list unless there are at least two therapeutically equivalent multisource generic drugs, or at least one generic drug available from at least one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers.''
MONTANA	
MT H 276 | 2017 **Reimbursement for Pharmacies** **Status:** Enacted - Act No. 136 **Last Action:** 03/31/2017 - Enacted - Act No. 136 **Author:** Greef (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Coverage in Insurance, Pharmacy Benefit Managers	Revises reimbursement for pharmacies, adding ''Reference pricing" which means a calculation for the price of a pharmaceutical that uses the most current nationally recognized reference price or amount to set the reimbursement for prescription drugs and other products, supplies, and services covered by a network contract between a plan sponsor, health insurance issuer, or pharmacy benefit manager and a pharmacy or pharmacist."
MT HJR 17 | 2017 **Prescription Drug Costs and Pricing** **Last Action:** 04/20/2017 - Enacted **Author:** Windy Boy (D) **Topics:** Pricing and Payment - Industry	Joint resolution, requests an interim study of prescription drug costs and pricing. Includes the cost of prescription drugs to the state Medicaid program, the Healthy Montana Kids Plan, state employee group benefit plans, and local government health plans, including how the costs have changed in recent years. The study is to develop recommendations for steps Montana could take to mitigate the effects of rising prescription drug prices on public programs and on Montanans, with completed report by Sept. 15, 2018.

Enacted Bill Information	Summary
MT S 211 | 2015 **Maximum Allowable Cost Lists for Prescription Drugs** **Last Action:** 05/05/2015 - Enacted - Act No. 431 **Author:** Buttrey (R) **Topics:** Rx Utilization Management, Rx Medicaid Use & Cost, Pharmacy Benefit Managers	Establishes procedures for maximum allowable cost lists for prescription drugs, requires disclosure of pricing sources, provides an appeal process, relates to pharmacy benefits managers.
NEVADA	
NV S 91 | 2017 **Drug Donation Programs** **Date of Last Action:** 05/26/2017 - Enacted - Act No. 153 **Author:** Hardy J (R) **Topics:** Pharmaceutical Pricing & Payment - Industry	Relates to prescription drug donation and reuse, combines the HIV and AIDs Drug Donation Program and the Cancer Drug Donation Program to create the Prescription Drug Donation Program, authorizes a person or governmental entity to donate certain drugs to the program.
NV S 366 | 2017 **Medicaid & Release of Health Insurance Claims Data** **Last Action:** 05/31/2017 - Enacted - Act No. 246 **Author:** Cancela (D) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Utilization Management, Rx Medicaid Use & Cost	Requires the preparation of a report relating to Medicaid recipients and access to employer-based health insurance, creates the Advisory Committee on Medicaid Innovation.
NV A 381 | 2017 **Prescription Drugs Covered by Health Insurance** **Last Action:** 06/01/2017 - Enacted - Act No. 281 **Author:** Spiegel (D) **Topics:** Pharmaceutical Pricing & Payment, Rx Coverage in Insurance, Cost Sharing & Deductibles	Prohibits an insurer from taking certain actions concerning prescription drugs covered by Individual and small group policies of health insurance. Restricts increasing co-payments to a higher cost tier from original coverage for a prescription drug pursuant to a formulary with more than one cost tier. The insurer may move the prescription drug from a lower cost tier to a higher cost tier only on Jan. 1 or annual start of the policy or when a new generic drug is approved by the FDA and is added to the lower tier list. Does not alter the ability of a pharmacist to substitute a generic or interchangeable biologic when it is available.
NV A 473 | 2017 **List of Preferred Prescription Drugs for Medicaid** **Last Action:** 06/04/2017 - Enacted - Act No. 350 **Author:** Health & Human Services Cmt **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Utilization Management, Rx Medicaid Use & Cost	Delays the prospective expiration of a provision governing the list of preferred prescription drugs (PDL) used for the Medicaid program. Until 2010, the Department was required to exclude certain antipsychotic medications, anticonvulsant medications and antidiabetic medications from the restrictions that are imposed on drugs which are on the list of preferred prescription drugs, but the Legislature suspended this requirement from 2010 to July 1, 2017. This allows Medicaid to include these medications in the state PDL for two more years, until July 2019, with a goal of encouraging use of preferred drugs and achieving cost containment.

Enacted Bill Information	Summary
NV S 539 | 2017 **Prescription Drugs** **Last Action:** 06/15/2017 - Enacted - Act No. 592 **Author:** Roberson (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Coverage in Insurance, Pharmacy Benefits Managers; Transparency	Requires the Department of Health and Human Services to compile lists of certain prescription drugs that are used to treat diabetes, requiring the manufacturer of a drug included on such lists and a pharmacy benefit manager to provide cost information to the Department, requiring the Department to compile a report based on such information, requiring submitting a list of each pharmaceutical sales representative who markets prescription drugs in this State, Requires pharmaceutical sales representatives to annually report interactions with doctors, including who they visited and what samples or gifts they handed out, for any compensation in excess of $10 or total compensation that exceeds $100. Health care nonprofits shall disclose contributions they receive from pharmaceutical companies by requiring the disclosure of contributions from PBMs and insurers as well. Also requires that any administrative penalties imposed on manufacturers, PBMs or nonprofits for failing to disclose the required information go toward funding diabetes education programs. Also requires certain medical facilities and facilities to disclose and post cost information near each public entrance to the facility and on any Internet website maintained by the facility.
NV S 14 | 2015 **Pharmacy & Therapeutics Committee** **Last Action:** 05/14/2015 - Enacted - Act No. 75 **Author:** Health & Human Services Cmt **Topics:** Rx Utilization Management, Rx Medicaid Use & Cost	Revises provisions governing the Pharmacy and Therapeutics Committee (P & T) within the Department of Health and Human Services to identify and review the prescription drugs which should be included on the list of preferred prescription drugs for the Medicaid program, eliminates the maximum limits on the number of members who may be active physicians or pharmacists or persons with a doctoral degree in pharmacy.
NEW HAMPSHIRE	
NH H 508 | 2016 **Medical Malpractice Joint Underwriting Association** **Status:** Enacted - Act No. 2015-263 **Last Action:** 07/20/2015 - Enacted - Act No. 2015-263 **Author:** Hunt Jo (R) **Topics:** Rx Coverage in Insurance, Cost Sharing & Deductibles	Prohibits insurers that cover expenses for intravenously administered, injected, and oral anti-cancer therapies from requiring an insured to pay a higher copayment, deductible, or coinsurance than for anti-cancer medications injected or intravenously administered by a health care provider, relates to cost-sharing parity for oral anti-cancer therapies.
NH H 1608 | 2016 **Uniform Prior Authorization Forms** **Last Action:** 06/09/2016 - Enacted - Act No. 2016-228 **Author:** Fothergill (R) **Additional Authors:** Bradley (R);Hunt Jo (R);Sherman (D);Woodburn (D) **Topics:** Rx Utilization Management, Rx Medicaid Use & Cost, Rx Coverage in Insurance	Requires health insurers, health maintenance organizations, health services corporations, medical services corporations, and preferred provider programs to use and accept only the uniform prior authorization forms and criteria developed by the Commissioner of Insurance in accordance with existing rules.

Enacted Bill Information	Summary
NH H 1680 | 2016 **Program Authorization & Medicaid Managed Care** **Last Action:** 06/06/2016 - Enacted - Act No. 2016-211 **Author:** Sherman (D) **Additional Authors:** Clark (D);Snow (D) **Topics:** Rx Utilization Management, Rx Medicaid Use & Cost	Extends the suspension of prior authorization requirements for a community mental health program on drugs used to treat mental illness under the Medicaid managed care program.
NH H 1664 | 2016 **Pharmacy Benefit Managers** **Status:** Enacted - Act No. 2016-177 **Date of Last Action:** 06/03/2016 - Enacted **Author:** Luneau (I) **Additional Authors:** Butler (D);Myler (D);Feltes (D) **Topics:** Coverage in Insurance , Pharmacy Benefit Managers	Relates to contracts between carriers or pharmacy benefit managers and pharmacies, establishes increased transparency for contracts between pharmacy benefit managers and contracted pharmacies for establishing MAC prices.
NH H 564 | 2015 **Prior Authorization for Prescription Drugs** **Last Action:** 07/06/2015 - Enacted - Act No. 2015-199 **Author:** Sherman (D) **Topics:** Access & Cost Sharing, Rx Medicaid Use & Cost, Rx Coverage in Insurance	Declares that a managed care health benefit plan offering prescription drug benefits shall not require prior authorization for certain drugs used to treat mental illnesses. The Department assumes the bill would apply to Medicaid Care Management health plans, but not to fee-for service Medicaid. The Department asked the Medicaid MCO's to report on the rate of prior authorization approval of behavioral health pharmaceuticals for a 6-month period in 2014 and those approval rates were 76.4% and 79%. The Department indicates an indeterminable amount of cost containment would be lost if prior authorization was prohibited. The Department suggests prior authorization serves purposes beyond the direct pecuniary.
NEW JERSEY	
NJ S 2015 | 2015 **Appropriations for Fiscal Year 2014-2015** **Last Action:** 06/30/2014 - Line Item Vetoed - Act No. 2014-14 **Author:** Sarlo (D) **Additional Authors:** Mosquera (D) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Medicaid Use & Cost	FY 2014-2015 state budget includes requirements for pharmaceutical reimbursements, ""... (1) the maximum allowable cost for legend and non-legend drugs shall be calculated based on the lowest of (i) the Estimated Acquisition Cost (EAC), defined as a drug's Wholesale Acquisition Cost less a volume discount of one (1) percent, (ii) the federal upper limit (FUL), or (iii) the State upper limit (SUL), and (iv) cost acquisition data submitted by providers of pharmaceutical services for single-source or brand-name multi-source drugs where an alternative pricing benchmark is not available, (2) pharmacy reimbursement for legend and non-legend drugs shall be calculated based on the (i) the lowest of the EAC, FUL or SUL plus a dispensing fee.''

Enacted Bill Information	Summary
NEW MEXICO	
NM H 274 | 2015 **Prescription Synchronization** **Last Action:** 04/07/2015 - Enacted - Act No. 65 **Author:** Armstrong (D) **Topics:** Access & Cost Sharing, Rx Utilization Management, Cost Sharing & Deductibles	Medicaid, group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act that offers a prescription drug benefit shall allow an enrollee to fill or refill a prescription for less than a thirty-day supply of the prescription drug, and apply a prorated daily copayment or coinsurance for the fill or refill, if: (1) the prescribing practitioner or the pharmacist determines it to be in the best interest of the patient, (2) the patient agrees to receive less than a thirty-day supply and (3) the reduced fill is made for the purpose of synchronizing the patient's prescription to make refill purchasing easier.
NEW YORK	
NY S 2007 | 2017 **Health & Mental Health Budget** **Last Action:** 04/20/2017 - Enacted - Act No. 57 **Author:** Office of the Governor **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Medicaid Use & Cost	Establishes a Medicaid drug cap. "The legislature hereby finds and declares that there is a significant public interest for the Medicaid program to manage drug costs in a manner that ensures patient access while providing financial stability for the state and participating providers. Therefore the department will 'establish a Medicaid drug cap as a separate component within the Medicaid global cap as part of a focused and sustained effort to balance the growth of drug expenditures with the growth of total Medicaid expenditures.'" Provides for Medicaid DUR board to follow "a recommendation for a target supplemental Medicaid rebate to be paid by the manufacturer of the drug to the department and the target amount of the rebate." If the state is unsuccessful in entering into a satisfactory rebate agreement, non-cooperating manufacturers will be required to file a detailed financial report including "actual cost of developing, manufacturing, producing... administrative, marketing, and advertising costs, including but not limited to prescriber detailing, copayment discount programs, and direct-to-consumer marketing, pricing used outside the U.S. and other specific statistics."
NY S 4721 | 2016 **Utilization Review of Prescription Drug Coverage** **Last Action:** 11/14/2016 - Enacted - Act No. 427 **Author:** Hannon (R) **Additional Authors:** Larkin (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Utilization Management	Directs the Commissioner of Health and Superintendent of Financial Services to establish a standard prior authorization request for a utilization review of prescription drug coverage by all health care plans for the purposes of submitting a request for a review determination for coverage of prescription drug benefits, include electronic prior authorization standard transactions.

Enacted Bill Information	Summary
NY A 3007 | 2015 **Public Health & Social Services Laws** **Last Action:** 04/13/2015 - Enacted - Act No. 57 **Author:** Office of the Governor **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Utilization Management, Rx Medicaid Use & Cost	Enacts provisions that relate to statewide supplemental rebates, the clinical drug review program, the prescriber prevails provision.
NORTH CAROLINA	
NC H 466 | 2017 ` **Pharmacy Benefit Managers** **Last Action:** Enacted - Act No. 2017-116 **Author:** Jones Br (R) **Additional Authors:** Willingham (D) **Associated Bills:** NC S 384 - Same as **Topics**: Pharmacy Benefit Managers	Relates to the regulation of pharmacy benefit managers, provides for consumer protections and for pharmacy and pharmacist protections. ''A pharmacy or pharmacist shall have the right to provide an insured information regarding the amount of the insured's cost share for a prescription drug. Neither a pharmacy nor a pharmacist shall be penalized by a pharmacy benefits manager for discussing any information described in this section or for selling a lower" priced drug to the insured if one is available.''
NC S 487 & S 384| 2015 **Health Choice Updated Provisions** **Last Action:** 06/19/2015 - Enacted - Act No. 2015-96 **Author:** Pate (R) **Additional Authors:** Hise (R) **Topics:** Rx Medicaid Use & Cost	Updates outdated provisions of the North Carolina Health Choice Program, defines comprehensive health coverage as creditable health coverage, provides that payments to prescription drug providers under Medicaid shall be paid in full and not subject to cost settlement.
NORTH DAKOTA	
ND S 2258 | 2017 **Pharmacy Claim Fees and Pharmacy Rights** **Last Action:** 04/05/2017 – Enacted as Act 161 **Author:** Jerry Klein (R) Additional Authors: Keiser (R), Vigesaa (R) , Dockter (R) , Armstrong (R) , **Topics:** Pharmacy Benefit Managers	Relates to pharmacy rights and pharmacy benefit managers; "A pharmacy or pharmacist may provide relevant information to a patient if the patient is acquiring prescription drugs. This information may include the cost and clinical efficacy of a more affordable alternative drug if one is available. Gag orders of such a nature placed on a pharmacy or pharmacist are prohibited." Provides that pay for performance pharmacy networks shall utilize the electronic quality improvement platform for plans and pharmacies or other unbiased nationally recognized entity; prohibits a fee requirement from a pharmacy benefits manager if metrics fall within the criteria for improvement.
ND H 1041 | 2015 **Medicaid Expansion Contracts** **Last Action:** 04/09/2015 - Enacted - Act No. 341 **Author:** Joint Interim Health Care Reform **Topics:** Rx Utilization Management, Rx Medicaid Use & Cost	Amends the Medicaid Expansion law, provides that if the state Department of Human Services implements the Medicaid Expansion program through a contract with a private carrier, the department shall issue one RFP (request for proposal) for the health insurance component of Medicaid Expansion, provides a reimbursement methodology for all medications and dispensing fees, allows an individual to obtain medication from a pharmacy that provides mail order service, ensures that pharmacy services are subject to authorization.

Enacted Bill Information	Summary
ND H 1072 | 2015 **Cancer Treatment Insurance Coverage** **Last Action:** 04/13/2015 - Enacted - Act No. 218 **Author:** Maragos (R) **Topics:** Access & Cost Sharing, Rx Coverage in Insurance, Cost Sharing & Deductibles	Requires that copayment, deductible, and coinsurance amounts for patient-administered cancer treatment medications do not exceed the amounts for cancer treatment medications that are injected or are intravenously administered by a health care provider, regardless of the formulation or benefit category, prohibits an insurer from increasing copayments or deductibles or reclassifying benefits in order to avoid compliance.
ND S 2320 | 2015 **Medication Therapy Management Program** **Last Action:** 04/13/2015 - Enacted - Act No. 331 **Author:** Lee J (R) **Topics:** Rx Utilization Management, Rx Medicaid Use & Cost	Establishes a medication therapy management program in the medical and hospital benefits coverage for Medicaid-eligible persons, provides that physicians, pharmacists, and other health professionals who provide face-to-face or telephonic medication therapy management services to covered individuals are entitled to reimbursement, provides for a formalized medication therapy program to facilitate enrollment procedures, enable consistent documentation, and structure an outcome reporting system.
OHIO	
OH S 129 | 2016 **Prior Authorization Requirements** **Last Action:** 06/13/2016 - Enacted - Act No. 2016-90 **Author:** Gardner (R) **Topics:** Rx Utilization Management, Rx Medicaid Use & Cost, Rx Coverage in Insurance	Amends the law related to the prior authorization requirements of insurers. Provides that ''If a policy, contract, or agreement issued by a health insuring corporation contains a prior authorization requirement, then the health insuring corporation shall:'' (1) Use the prior authorization form adopted by the superintendent of insurance for all requests or notifications made under a prior authorization requirement. (2) Have the prior authorization requirement be based on clinical review criteria guidelines that: (a) Developed and endorsed by an independent, multidisciplinary panel of experts not affiliated with the health insuring corporation, (b) Based on high quality studies, research, and medical practice, (c) Created by a transparent process that does all of the following: (i) Minimizes biases and conflicts of interest, (ii) Explains the relationship between treatment options and outcomes, (iii) Rates the quality of the evidence supporting recommendations, (iv).
OKLAHOMA	
OK H 1824 | 2018 **Health Benefit Plans** **Last Action:** 05/01/2017 - Enacted - Act No. 140 **Author:** Kannady (R) **Topics:** Rx Coverage in Insurance, Cost Sharing & Deductibles	Requires health benefit plans to provide for synchronization of prescription drug refills and prorate cost-sharing charges for prescription drugs under certain circumstances, prohibits proration of dispensing fees, requires that dispensing fees be based on the number of prescriptions filled or refilled, defines term, provides for codification, provides an effective date.

Enacted Bill Information	Summary
OK H 1824 | 2017 **Health Benefit Plans** **Last Action:** 05/01/2017 - Enacted - Act No. 140 **Author:** Kannady (R) **Topics:** Rx Coverage in Insurance, Cost Sharing & Deductibles	Requires health benefit plans to provide for synchronization of prescription drug refills and prorate cost-sharing charges for prescription drugs under certain circumstances, prohibits proration of dispensing fees, requires that dispensing fees be based on the number of prescriptions filled or refilled, defines term, provides for codification.
OREGON	
OR H 2300 | 2017 **Mental Health Drugs & Global Budgets** **Last Action:** 08/02/2017 - Enacted - Act No. 619 **Author:** Office of the Governor **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Coverage in Insurance	Establishes Mental Health Clinical Advisory Group in Oregon Health Authority to develop evidence-based algorithms for prescription drug treatment of mental health disorders in medical assistance recipients, specifies membership, requires Oregon Health Authority to reimburse cost of mental health drugs for medical assistance recipients.
OR S 841 | 2015 **Health Plan Coverage** **Last Action:** 07/27/2015 - Enacted - Act No. 800 **Author:** Bates (D) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Medicaid Use & Cost	Modifies requirements for health plan coverage of prescription drugs dispensed in accordance with synchronization policy, requires Oregon Health Authority to implement synchronization policy for dispensing of prescription drugs to medical assistance recipients who are not enrolled in coordinated care organization.
OR H 2028 | 2015 **Clinical Pharmacy** **Last Action:** 06/11/2015 - Enacted - Act No. 362 **Author:** Health Care Cmt **Topics:** Pharmaceutical Pricing & Payment - Industry	Permits pharmacists to engage in practice of clinical pharmacy and provide patient care services to patients, permits health insurers and the State Health Authority to provide payment or reimbursement for services provided by pharmacist through practice of clinical pharmacy or pursuant to statewide drug therapy management protocol, defines clinical pharmacy agreement and practice of clinical pharmacy, relates to pharmacy services, relates to rules adopted by the State Board of Pharmacy.
OR H 2306 | 2015 **Medical Assistance Recipient Prescription Drugs** **Status:** Enacted - Act No. 467 **Last Action:** 06/18/2015 - Enacted - Act No. 467 **Author:** Health Care Cmt **Topics:** Rx Medicaid Use & Cost	Authorizes Oregon Health Authority to limit providers from which medical assistance recipient may obtain prescription drugs: ''if necessary to avoid overutilization by a recipient of medical assistance, the Oregon Health Authority may restrict, for 18 months or less, the recipient's pharmacy choices for filling and refilling prescriptions to a mail order pharmacy that contracts with the authority, a retail pharmacy selected by the recipient and a specialty pharmacy selected by the recipient, for beneficiaries who exhibit patterns of over use.

Enacted Bill Information	Summary
OR H 2638 | 2015 **State Prescription Drug Program** **Last Action:** 06/25/2015 - Enacted - Act No. 551 **Author:** Lively (D) **Topics:** Access & Cost Sharing, Rx Utilization Management, Rx Medicaid Use & Cost	Permits medical assistance (Medicaid) recipients and coordinated care organizations to use the Oregon Prescription Drug Program's discount pricing, allows Oregon Health Authority to deny reimbursement of any new prescription drug until six months after approval of drug by United States Food and Drug Administration.
RHODE ISLAND	
RI S 2467 | 2016 **Prescription Drug Benefits** **Last Action:** 06/29/2016 - Enacted - Act No. 2016-166 **Author:** Walaska (D) **Additional Authors:** Cote (D);McCaffrey (D);Ciccone (D) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Coverage in Insurance, pharmacy benefit managers	Regulates business relationships among pharmacy services providers, group health insurers, and health service organizations by providing department of health oversight. Pharmacy benefit manager (PBM) are required to disclose prices with respect to multi-source generic pricing and provide updates on prices to pharmacies every 10 days.
RI S 893 | 2018 **Prescription Insurance Coverage Change Notification** **Last Action:** 09/29/2017 - Enacted - Act No. 2017-361 **Author:** Crowley (D) **Additional Authors:** Sosnowski (D);Miller (D);Quezada (D) **Topics:** Rx Coverage in Insurance; Cost Sharing & Deductibles	Specifies that all adversely affected members of a formulary change removing a covered prescription drug or making a change in the drug's preferred or tiered cost sharing status receive required statutory notification.
RI H 6322 | 2018 **Accident & Sickness Insurance Policies** **Last Action:** 07/21/2017 - Enacted - Act No. 2017-274 **Author:** Ackerman (D) **Additional Authors:** Craven (D);Marshall (D);Carson (D);Fogarty (D) **Topics:** Rx Coverage in Insurance; Cost Sharing & Deductibles	Specifies that all patients adversely affected by a formulary change, removing a covered prescription drug or making a change in the drug's preferred or tiered cost sharing status, receive advance notification.
SOUTH CAROLINA	
SC S 849 | 2016 **Maximum Allowable Cost Lists & Requirements** **Last Action:** 05/02/2016 - Enacted - Act No. 163 **Author:** Cromer (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Medicaid Use & Cost	Provides procedures governing the maximum allowable cost reimbursements for generic prescription drugs by pharmacy benefit managers, provides necessary definitions, exempts the Department of Health and Human Services in the performance of its duties in administering Medicaid, provides requirements for placing drugs on maximum allowable cost lists by pharmacy benefit managers, relates to contracts between pharmacies and pharmacy benefit managers.

Enacted Bill Information	Summary
SOUTH DAKOTA	
SD S 101 | 2015 **Cancer Treatment Medication Insurance Coverage** **Last Action:** 03/12/2015 - Enacted - Act No. 252 **Author:** Peters (R) **Topics:** Access & Cost Sharing, Rx Coverage in Insurance, Cost Sharing & Deductibles	Provides that a health benefit plan that covers injected or intravenously administered cancer treatment medication shall provide no less favorable benefits for prescribed, orally administered anticancer medication, regardless of formulation or benefit category, prohibits an insurer to reclassify benefits for cancer treatment medications or to increase a copayment, deductible, or coinsurance amount unless the increase is applied to all benefits.
SD S 118 | 2015 **Additional Transparency for Prescription Drug Plans** **Last Action:** 03/11/2015 - Enacted - Act No. 251 **Author:** Rampelberg (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Access & Cost Sharing, Rx Utilization Management, Rx Coverage in Insurance	Provides additional transparency for prescription drug plans, requires health insurers to provide plan information to enrollees regarding prescription drugs and drugs administered in a physician office or clinic, an online list of providers and facilities, drug formularies and a description of an easily accessible method to obtain a prior authorization or step edit requirement for each specific drug included on the formulary, excludes plans that are not actively marketed by a carrier. (Does not require action by drug manufacturers)
TENNESSEE	
TN H 628 | 2018 **Bureau of TennCare** **Last Action:** 05/11/2017 - Enacted - Act No. 363 **Author:** Kumar (R) **Additional Authors:** Brooks K (R);Ragan (R);Holsclaw (R);Terry (R) **Topics:** Rx Utilization Management, Rx Medicaid Use & Cost	Requires the bureau of TennCare to report to the senate Health and Welfare Committee and the health committee of the house of representatives concerning the effects of incorporating medication therapy management into its healthcare delivery systems by the specified date.
TN S 1789 | 2016 **Pharmacy & Pharmacy Services** **Last Action:** 03/23/2016 - Enacted - Act No. 631 **Author:** Overbey (R) **Additional Authors:** McNally (R);Bell (R);Yager (R);Haile (R) **Topics:** Pharmaceutical Pricing & Payment - Industry	Allows a pharmacy to designate a pharmacy services administrative organization to file and handle an appeal challenging the maximum allowable cost set for a particular drug or medical product or device (usually by a PBM) on behalf of the pharmacy.
TEXAS	
TX S 1076 | 2017 **Health Benefit Plan for Prescription Drugs Coverage** **Last Action:** 06/12/2017 - Enacted - Act No. 727 **Author:** Schwertner (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Cost Sharing & Deductibles, PBMs	Limits the copayment amounts charged to an enrollee in a health benefit plan for prescription drugs covered by the plan, and not more than the claim amount or the purchase price without using "a health benefit plan or any other source of drug benefit or discount.

Enacted Bill Information	Summary
TX H 1227 | 2017 **Transparency of Prescription Drug Coverage** **Last Action:** 05/26/2017 - Enacted - Act No. 135 **Author:** Smithee (R) **Topics:** Rx Coverage in Insurance, Cost Sharing & Deductibles	Requires that a ''health benefit plan issuer shall display on a public Internet website maintained by the issuer formulary information for each of the issuer's individual health plans.''
TX H 1296 | 2017 **Health Benefit Coverage for Prescription Drugs** **Last Action:** 06/15/2017 - Enacted - Act No. 1007 **Author:** Frullo (R) **Additional Authors:** Zerwas (R);&erson R (R);Larson (R);Raney (R);Guerra (D);Sheffield J (R);Oliverson (R) **Topics:** Rx Utilization Management, Rx Coverage in Insurance, Cost Sharing & Deductibles	Relates to health benefit coverage for prescription drug synchronization, requires certain health benefit plans to cover certain medications; requires a health benefit plan providing benefits for prescription drugs to prorate any cost-sharing amount charged for partial supply of a drug under certain circumstances; relates only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness.
TX H 1917 | 2017 **Contract Requirements for Prescription Drug Benefits** **Last Action:** 06/15/2017 - Enacted - Act No. 832 **Author:** Raymond (D) **Topics:** Rx Medicaid Use & Cost	Relaxes contract restrictions and prohibitions on Medicaid managed care organizations through 2023. Provides exceptions for organizations requiring waivers from the federal government.
TX S 219 | 2015 **Health & Human Services** **Last Action:** 04/02/2015 - Enacted - Act No. 1 **Author:** Schwertner (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Coverage in Insurance	Relates to the provision of health and human services in this state, including the powers and duties of the Health and Human Services Commission and other state agencies establishing that “policies and procedures for reclassifying prescription drugs from retail to specialty drugs, and those policies and procedures must be consistent with rules adopted by the executive commissioner and include notice to network pharmacy providers from the managed care organization.”
TX S 332 | 2015 **Pharmacy Benefits Maximum Allowable Cost Lists** **Last Action:** 06/16/2015 - Enacted - Act No. 596 **Author:** Schwertner (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Utilization Management, Rx Coverage in Insurance	Prohibits a health benefit plan issuer or pharmacy benefit manager (PBM) from including a drug on a maximum allowable cost list unless the drug meets certain specifications, requires certain disclosures.
TX S 460 | 2015 **Pharmacists & Pharmacies Licensing & Regulation** **Last Action:** 06/16/2015 - Enacted - Act No. 599 **Author:** Schwertner (R) **Topics:** Pharmaceutical Pricing & Payment - Industry	Provides an electronic messaging system to provide for pharmacy complaints, provides for procedures governing the inspection of financial records during the course of a complaint investigation, relates to supplying pharmacist's records of practice outside the pharmacy, requires notification of pharmacy change of location.

Enacted Bill Information	Summary
TX S 760 | 2015 **Investigation of Health Care & Long Term Services.** **Last Action:** 06/20/2015 - Enacted - Act No. 1272 **Author:** Schwertner (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Medicaid Use & Cost	Provides “policies and procedures for reclassifying prescription drugs from retail to specialty drugs, and those policies and procedures must be consistent with rules adopted by the executive commissioner and include notice to network pharmacy providers” from the managed care organization.
TX H 1624 | 2015 **Health Benefit Plan Coverage Information Transparency** **Last Action:** 06/19/2015 - Enacted - Act No. 1038 **Author:** Smithee (R) **Topics:** Rx Coverage in Insurance, Cost Sharing & Deductibles	Relates to transparency of certain information related to certain health benefit plan coverage, provides a health benefit plan issuer shall display on a public Internet website maintained by the issuer formulary information as required by the Insurance Commissioner by rule, provides the manner in which the information is to be displayed, requires the Commissioner to develop and adopt requirements to promote consistency and clarity in the disclosure of formularies.
UTAH	
UT H 148 | 2015 **State Employee Health Clinic** **Last Action:** 03/23/2015 - Enacted - Act No. 068 **Author:** Barlow (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Access & Cost Sharing, Rx Coverage in Insurance	Amends the Public Employees' Benefit and Insurance Program Act to establish a pilot program for a state employee health clinic, provides for bidding, increase compliance with health care screening and management of chronic health care conditions and dispensing of commonly used, pre-packaged drugs in a cost effective manner.
VERMONT	
VT S 216 | 2016 **Prescription Drugs** **Last Action:** 06/02/2016 - Enacted - Act No. 165 **Author:** Mullin (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Coverage in Insurance	Provides for pharmaceutical cost transparency, requiring the state to do an annual identification of up to 15 state purchased prescription drugs ''on which the State spends significant health care dollars and for which the wholesale acquisition cost has increased by 50 percent or more over the past five years or by 15 percent or more over the past 12 months, creating a substantial public interest in understanding the development of the drugs' pricing.'' The state attorney general ""shall require the drug's manufacturer to provide a justification for the increase in the wholesale acquisition cost of the drug"" in a understandable and appropriate format. Requires that rules be adopted requiring certain insurers to provide information about the State Health Benefit Exchange plan's drug formularies, provides further for drug dispensing fees, reimbursement, a related report and out-of-pocket drug limits.

Enacted Bill Information	Summary
VT H 620 | 2016 **Contraceptives Health Insurance & Medicaid Coverage** **Last Action:** 05/23/2016 - Enacted - Act No. 120 **Author:** Pugh (D) **Additional Authors:** Head (D);Briglin (D);Toleno (D);Krowinski (D);Pearson (P);Buxton (D);Till (D);Stevens T (D);Hooper (D);Burke (P);Mrowicki (D);Komline (R);Copel&-Hanzas (D);Sibilia (I) **Topics:** Rx Medicaid Use & Cost, Rx Coverage in Insurance	Specifies the contraceptive products and services that must be included in health insurance plans, as well as restrictions on cost-sharing for contraceptive services, directs the Department of Vermont Health Access to establish value-based payments for the insertion and removal of long-acting reversible contraceptives comparable to those for oral contraceptives, relates to Medicaid and public health care assistance.
VT H 18 | 2015 **Public Records Act Exemptions** **Last Action:** 05/26/2015 - Enacted - Act No. 29 **Author:** Sweaney (D) **Topics:** Pharmaceutical Pricing & Payment - Industry	Requires the Office of Legislative council to compile a list of all Public Records Act exemptions, requires the list to be posted on specified websites, makes changes concerning records acquired or produced by certain institutional student assistance, income, insurance agent records, life settlement records, prescription drug price information, and applicants for certain assistance.
VIRGINIA	
VA H 308 | 2015 **Health Insurance & Prescription Drugs** **Last Action:** 03/24/2014 - Enacted - Act No. 272 **Author:** Dance (D) **Additional Authors:** Ward (D);Peace (R);Keam (D) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Utilization Management, Rx Coverage in Insurance	Requires any health insurer, corporation providing individual, group accident, and sickness subscription contracts, or health maintenance organization that applies a formulary to prescription drug benefits provided under its policy, contract, or plan to provide prior written notice to each insured of a formulary modification that results in the movement of the drug to a tier with a higher cost.
VA H 2031 | 2015 **Health Insurance Costs & Pharmacy Reimbursement** **Last Action:** 03/23/2015 - Enacted - Act No. 518 **Author:** Yost (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Coverage in Insurance	Requires any pharmacy benefits contract or provider contract entered into, amended, extended, or renewed on or after a specified date, that provides for the use of maximum allowable cost as the basis for the amount of any reimbursement or payment of claims to a pharmacist or another person shall contain specific provisions that require a process for an appeal, investigation or resolution of pricing disputes.

Enacted Bill Information	Summary
WASHINGTON	
WA S 5441 | 2015 **Patient Medication Coordination** **Last Action:** 05/08/2015 - Enacted - Act No. 213 **Author:** Rivers (R) **Topics:** Access & Cost Sharing, Rx Coverage in Insurance, Cost Sharing & Deductibles	Requires health benefit plans that cover prescription drugs to implement a medication synchronization policy and to permit an enrollee to fill a drug for more or less than a one-month supply if the enrollee requests medication synchronization for a new medication, requires such plans to adjust enrollee cost-sharing on a prorated basis.
WEST VIRGINIA	
WV H 2493 | 2015 **Requirements for Insurance Policies & Contracts** **Last Action:** 03/25/2015 - Enacted - Act No. 146 **Author:** McCuskey (R) **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Coverage in Insurance, Cost Sharing & Deductibles	Provides for accident and sickness insurance coverage of anti-cancer medications, provides for direct health care services that cover anti-cancer medications, prohibits unequal copayments, deductibles or coinsurance for by stating that policies ""may not require a less favorable basis for a copayment, deductible or coinsurance amount for patient administered anti-cancer medications than it requires for injected or intravenously administered anti-cancer medications,"" allows cost containment measures.
WISCONSIN	
WI S 21 | 2016 **Executive Budget Act** **Last Action:** 07/12/2015 - Line Item Vetoed - Act No. 55 **Author:** Joint Finance **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Coverage in Insurance	Authorizes the administrator of the division of personnel management in the department of administration to establish, on a annual basis, the amount that state employees are required to contribute to state health plans. Allows the administrator to distribute health insurance credits to retired state personnel and their dependents for the purposes of purchasing health insurance.
WI S 238 | 2016 **Billing Medical Assistance for Prescription Drugs** **Last Action:** 02/18/2016 - Enacted - Act No. 152 **Author:** Kapenga (R) **Topics:** Rx Medicaid Use & Cost	Relates to billing the Medical Assistance program for prescription drugs by certain entities, relates to billing by certain abortion providers and related dispensing fees.

Enacted Bill Information	Summary
WYOMING	
WY S 121 | 2017 **Pharmacy Act** **Date of Last Action:** 03/06/2017 - Enacted - Act No. 169 **Author:** Baldwin (R) **Additional Authors:** Dockstader (R);Barlow (R);Walters (R) **Topics:** Utilization Management - Rx Drugs	Modifies drug substitution procedures, allowing a pharmacist to dispense a generic for a brand name prescription drug, unless the prescriber specifies that substitution is not permitted. Makes minor adjustments in penalties, to include ''other disciplinary action against the licensee by a board of pharmacy.''
WY H 35 | 2016 **Insurance & Pharmacy Benefits** **Last Action:** 03/04/2016 - Enacted - Act No. 90 **Author:** Joint Interim Corporations, Elections **Topics:** Pharmaceutical Pricing & Payment - Industry, Rx Coverage in Insurance	Relates to regulation and require licensure of pharmacy benefit managers (PBMs), establishes a new licensing fee of $500 annually, provides requirements for audits conducted by pharmacy benefit managers, provides requirements and restrictions for placing generic drugs on maximum allowable cost lists, protecting the business interests of pharmacies and pharmacists.
WY S 62 | 2015 **Oral Chemotherapy** **Last Action:** 03/02/2015 - Enacted - Act No. 94 **Author:** &erson Ja (R) **Topics:** Access & Cost Sharing, Rx Coverage in Insurance, Cost Sharing & Deductibles	Requires that insurers provide individual and group coverage for oral chemotherapy in the same manner as injectable and intravenous chemotherapy, provides applicability, prohibits increasing the copayment, deductible or coinsurance amount required for covered injected or intravenous chemotherapy or by reclassifying benefits with respect to cancer treatment medications.

Index

The NCSL Prescription Drug Policy Resource Center is supported in part by a grant from the Laura and John Arnold Foundation, for reseach and educational resources conducted November 2017-2019. Editorial content is the sole responsibility of NCSL.

The NCSL online database has been designed and maintained as a member and public resource, funded by NCSL general funds. It is available for use at no charge, with no password restriction.

All information containd in this report and the online database is intended for general information, and should not be considered legal or medical advice. Enacted bills are a snapshot in time, and are subject to subsequent amendment, regulatory modification or clarification, as well as judicial actions. Users are encouraged to use the full text links for a more complete understanding of each law.

COMING SUMMER 2018:
NCSL 2018 Prescription Drug Update, describing latest enactments from January 1 through June 2018.

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

A Look at the Total Plan

2017 Plan Cost	
Average Wholesale Price	$189,129,667
Network & Mail Discount Savings (includes dispensing fees)	-$101,088,835
Taxes (Applies to certain out-of-state purchases)	$1,758
2017 Total Gross Cost:	$88,042,591
Less Member Cost Share:	-$5,329,478
Total Plan Cost:	$82,708,004
Less Rebates:	-$17,340,807
Less EGWP Subsidies:	-$8,012,650
Admin Fees:	$1,277,647
Adjusted Net Cost:	$58,632,194

# Rx Filled	Cost PMPM	Cost Per Rx	Generic Fill Rate
584,073	$185.40	$141.61	86.5%

Source: Express Scripts' 2017 SONH Rx Plan Annual Review

11

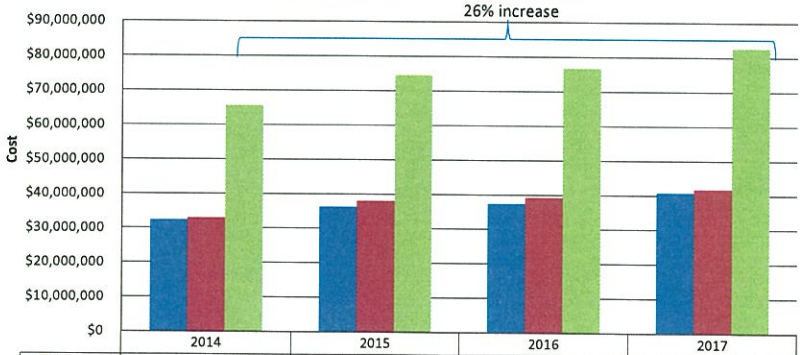
DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

Even though the total retiree population is approximately 50% less than the active population, retiree plan costs have exceeded active plan costs by an average of $1.4m/yr. since 2014.

Total Plan Cost by Plan by Year*



	2014	2015	2016	2017
Active	$32,447,907	$36,356,062	$37,530,324	$40,798,507
Retirees	$33,242,166	$38,212,308	$39,336,301	$41,909,497
Annual Total	$65,690,073	$74,568,370	$76,866,625	$82,708,004

*Total plan cost less member cost share

Source: Express Scripts' 2014- 2017 SONH Rx Plan Annual Reviews

12

Appendix E

New Hampshire Pharmacists Association
NHPA
Established • 1873 •

October 22 2018

To Representative Hennessy and Senator Soucy and members of the Commission To Study Greater Transparency In Pharmaceutical Costs And Drug Rebate Programs and the Committee To Study The Impact Of Pharmacy Benefit Manager Operations On Cost, Administration, And Distribution Of Prescription Drugs.

NHPA's position regarding transparency is as follows.

As working pharmacists we feel that the more transparency there is in drug pricing the better. We would like to have as much information as possible to convey to our patients so that each party (patients, prescribers, and dispensers) can collaborate to make the most informed decision possible for a patient's therapy. It does not help the patient in any way when a treatment is decided on only to find out it is not affordable. That wastes the time of the prescriber, the dispenser, and most importantly the patient. In this day and age of information on demand it seems foolish that drug prices are so variable and their calculations shrouded in mystery and undisclosed back room kickbacks. The following is a detailed list of what would be needed to make drug prices 100% transparent. We understand that all these points may not be possible, but it would be a truly transparent model that we could work towards.

Transparency must be addressed as follows:

- *A true definition of transparency as it relates to this issue*
- **Legislation requiring PBM's to fully disclose their rebate procedures. This must include full disclosure of SPREADS.** Disclosure must NOT be in the aggregate, but in a line-by-line fashion. That is, Drug Cost to Employer – Drug payout to provider = SPREAD
- PBM must return all SPREAD to the consumer which will lower consumer expense exposure.
- **Calculation of consumer Co-Payments and/or Cost Shares** must begin with utilizing proper product cost. (e.g. LIST price, AWP, AMP, ACQ).
- **Formularies:** PBM formularies must be disclosed. Again, not as an aggregate but rather a line-by-line listing with elaborate disclosure of drug cost, drug, rebate etc.
- **Rebates: Rebates paid by Manufacturers to PBM must be fully disclosed by the manufacturer. Rebates received by the PBM from the manufacturer must be fully disclosed by the PBM. These reports should not be in the aggregate but rather a line-by-line listing of each drug receiving a rebate. PBM must report whether rebates are used to defray administrative costs.**
- **Coupons/Discount Cards - ALL EXPENSES generated by usage of Coupons/Discount cards shall be absorbed by the PBM and/or Drug Manufacturer. As these cards either lower PBM cost exposure or increase Manufacturer market share, the burden of transmission fees, processing fees or any type of fee imposed upon a pharmacy should be prohibited**. In no way shall any costs associated with usage of such vehicles be passed through to the provider.

Respectfully Submitted
Richard Cohen RPH
NHPA