Committee Report

CONSENT CALENDAR

March 20, 2019

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Committee on Commerce and Consumer Affairs to which was referred HB 657,

AN ACT relative to the lowest cost option in the formulary under the managed care law. Having considered the same, report the same with the following amendment, and the recommendation that the bill OUGHT TO PASS WITH AMENDMENT.

Rep. Garrett Muscatel

FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

COMMITTEE REPORT

Committee:	**Commerce and Consumer Affairs**
Bill Number:	**HB 657**
Title:	**relative to the lowest cost option in the formulary under the managed care law.**
Date:	**March 20, 2019**
Consent Calendar:	**CONSENT**
Recommendation:	**OUGHT TO PASS WITH AMENDMENT 2019-0906h**

STATEMENT OF INTENT

As amended, this bill provides an exception process for an individual who is on a low cost drug to continue to take that drug if it is taken off their insurance carrier's formulary. The committee heard that a fellow representative testified about an inability to stay on a low cost drug after it was taken off their formulary. This bill addresses that concern by clarifying and expanding an existing exception process. This process will be beneficial to consumers because using lower cost drugs will help to bring down premiums. This exception process was agreed to as beneficial by the various industry groups involved. The committee believes that this bill fixes a loophole in the low cost drug approval process and allows individuals to continue to use their drugs in the event they are taken off their formulary.

Vote 20-0.

Rep. Garrett Muscatel
FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

CONSENT CALENDAR

Commerce and Consumer Affairs

HB 657, relative to the lowest cost option in the formulary under the managed care law. **OUGHT TO PASS WITH AMENDMENT.**

Rep. Garrett Muscatel for Commerce and Consumer Affairs. As amended, this bill provides an exception process for an individual who is on a low cost drug to continue to take that drug if it is taken off their insurance carrier's formulary. The committee heard that a fellow representative testified about an inability to stay on a low cost drug after it was taken off their formulary. This bill addresses that concern by clarifying and expanding an existing exception process. This process will be beneficial to consumers because using lower cost drugs will help to bring down premiums. This exception process was agreed to as beneficial by the various industry groups involved. The committee believes that this bill fixes a loophole in the low cost drug approval process and allows individuals to continue to use their drugs in the event they are taken off their formulary. **Vote 20-0.**

Original: House Clerk
Cc: Committee Bill File

Stapler, Carol

From: Garrett Muscatel <repmuscatel@gmail.com>
Sent: Wednesday, March 13, 2019 10:38 AM
To: Stapler, Carol
Subject: Committee Reports

Hey Carol,

Here are my remaining committee reports.

656 2/19

This bill establishes a commision to study financial incentives between insurance companies, pharmacy benefit managers, and pharmaceutical manufacturers on drug prices and insurance premiums. The committee heard that there is a stunning lack of transparency in how insured individuals get their prescription drugs, and it came about as a recommendation from last year's commission which studied this industry with a broader lense. With the skyrocketing costs of prescription drugs, removing the veil from this complicated system will allow us to better understand how financial incentives, ranging from rebates to PBMs from manufacturers to copay coupons for consumers at the pharmacy counter, impact these rising costs. With a better understanding of this process, this commision will be able to suggest future legislation improve the market for prescription drugs in this state. The committee feels that more information will be incredibly valuable to understanding how financial incentives contribute the rising costs of drugs.

657 2/19

As amended, this bill provides an exception process for an individual who is on a low cost drug to continue to take that drug if it is taken off the formulary. The committee heard that a fellow representative testified about an inability to stay on a low cost drug after it was taken off their formulary, and this bill addresses that concern by clarifying and expanding an existing exception process. This process will be beneficial to consumers because using lower cost drugs will help to bring down premiums, and this exception process was agreed to as beneficial by various industry groups involved. The committee believes that this bill fixes a loophole in the low cost drug approval process and allows individuals to continue to use their drugs in the event they are taken off their formulary.

670 2/19

Rep. Muscatel, Graf. 12
March 8, 2019
2019-0906h
01/04

Amendment to HB 657

Amend the title of the bill by replacing it with the following:

AN ACT relative to prescription drugs under the managed care law.

Amend the bill by replacing all after the enacting clause with the following:

1 Managed Care Law; Prescription Drugs. Amend RSA 420-J:7-b, II through III to read as follows:

II. Every health benefit plan that provides prescription drug benefits shall maintain an expeditious exception process, not to exceed 48 hours, by which covered persons may obtain coverage for a medically necessary nonformulary prescription drug ***or for a nonformulary prescription drug that was available during the previous 12 months.*** The exception process shall begin when the prescribing provider has submitted a request with a clinical rationale for the exception to the health benefit plan. ***The exception process shall also begin when a covered person has submitted a non-clinical request for access to a drug approved by the federal Food and Drug Administration for treating a specific condition when such drug was available on the formulary during the previous 12 months.*** A prescription that requires an exception for coverage shall be considered approved if the exception process exceeds 48 hours.

II-a. No health benefit plan that provides prescription drug benefits and establishes the specific sequence in which prescription drugs for a medical condition are to be prescribed shall require failure on the same medication on more than one occasion for patients continuously enrolled in the plan. Nothing in this section shall be construed to prevent a health care provider from prescribing a medication to the same patient on more than one occasion, when he or she determines it is medically appropriate.

III. Every health plan that provides prescription drug benefits shall [~~notify~~] ***provide written notice in a conspicuous font and size to*** covered persons affected by deletions to the plan list or plan formulary, provide an explanation of the exception process by which a covered person can access nonformulary medically necessary prescription drugs, and provide a toll-free telephone number through which a covered person can request additional information. For purposes of this paragraph, covered persons affected by deletions to the plan list or plan formulary shall include those covered persons for whom the health plan has provided coverage for the deleted prescription drugs during the 12-month period immediately prior to the deletion. Upon notification

to covered persons, the health benefit plan shall allow at least 45 days before implementation of any formulary deletions; provided, however, that advance notice shall not be required if the federal Food and Drug Administration has determined that a prescription drug on the health benefit plan's formulary is unsafe. ***For purposes of this section, "conspicuous font and size" shall mean a font that is at least 12 point in size and in an easily legible font. If a covered person avails him or herself of the exception process as outlined in 420-J:7-b, II, the medication shall be covered by the health plan until there is a resolution of the exception process.***

2 Managed Care Law; Prescription Drugs. Amend RSA 420-J:7-b, IX(a) to read as follows:

IX.(a) Every health benefit plan that provides prescription drug benefits shall allow its covered persons to obtain an emergency prescription for up to a 72-hour supply of covered prescription drugs on the covered person's health benefit plan formulary ***or a prescription drug that was deleted from the formulary within the last 90 days*** in the event a prescription requires prior authorization ***or an exception*** by an insurance carrier and the prior authorization ***or exception*** has neither been approved nor denied and a pharmacist has determined the medication is essential as provided in RSA 318:47-i. Such reimbursement shall be according to the payment rates of the provider contract. If authorization ***or exception*** is subsequently denied, the carrier shall reimburse the pharmacist for the prescription as given based on the pro-rated amount they would have otherwise received under the terms of the provider contract.

3 Effective Date. This act shall take effect 60 days after its passage.

Voting Sheets

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

EXECUTIVE SESSION on HB 657

BILL TITLE: (New Title) relative to prescription drugs under the managed care law.

DATE: March 8, 2019

LOB ROOM: 302

MOTIONS: **OUGHT TO PASS WITH AMENDMENT**

Moved by Rep. Muscatel	Seconded by Rep. Butler	AM Vote: 20-0

Amendment # 2019-0906h

Moved by Rep. Muscatel	Seconded by Rep. Butler	Vote: 20-0

CONSENT CALENDAR: YES

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep Constance Van Houten, Acting Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

EXECUTIVE SESSION on HB 657

BILL TITLE: relative to the lowest cost option in the formulary under the managed care law.

DATE: 3-8-19

LOB ROOM: 302

MOTION: (Please check one box)

☑ OTP ☐ ITL ☐ Retain (1st year) ☑ Adoption of Amendment # 2019-0906 H *(if offered)*

☐ Interim Study (2nd year)

Moved by Rep. Muscatel Seconded by Rep. Butler Vote: 20-0

MOTION: (Please check one box)

☐ OTP ☑ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # ____ *(if offered)*

☐ Interim Study (2nd year)

Moved by Rep. Muscatel Seconded by Rep. Butler Vote: 20-0

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # ____ *(if offered)*

☐ Interim Study (2nd year)

Moved by Rep. _____ Seconded by Rep. _____ Vote: ____

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # ____ *(if offered)*

☐ Interim Study (2nd year)

Moved by Rep. _____ Seconded by Rep. _____ Vote: ____

CONSENT CALENDAR: ✓ YES ____ NO

Minority Report? ____ Yes ____ No If yes, author, Rep: _____ Motion____

Respectfully submitted: Constance Van Houten

~~Rep Rebecca McBeath, Clerk~~

OFFICE OF THE HOUSE CLERK

1/14/2019 3:15:04 PM
Roll Call Committee Registers Report

2019 SESSION

Commerce and Consumer Affairs

Bill #: 657 Motion: adopt AM #: 0906h Exec Session Date: 3/8/2019

Members	YEAS	Nays	NV
Butler, Edward A. Chairman	X		
Williams, Kermit R. Vice Chairman	X		
~~Gidge, Kenneth N.~~ Schultz	X		
Abel, Richard M.	X		
~~McBeath, Rebecca Susan Clerk~~ Rung	X		
Bartlett, Christy D.	X		
Herbert, Christopher J.	X		
Van Houten, Constance	X		
~~Fargo, Kristina M.~~ McConnell	X		
Indruk, Greg L.	X		
Muscatel, Garrett D.	X		
Weston, Joyce	X		
Hunt, John B.	X		
~~Sanborn, Laurie J.~~ BURNS	X		
Osborne, Jason M.	X		
Costable, Michael	X		
Plumer, John R.	X		
Barnes, Arthur E.	X		
Potucek, John M.	X		
~~Warden, Mark~~ Spilane	X		
TOTAL VOTE: 20-0			

OFFICE OF THE HOUSE CLERK

1/14/2019 3:15:04 PM
Roll Call Committee Registers Report

2019 SESSION

Commerce and Consumer Affairs

Bill #: 657 Motion: OTPA AM #: 0906h Exec Session Date: 2/8/2019

Members	YEAS	Nays	NV
Butler, Edward A. Chairman	X		
Williams, Kermit R. Vice Chairman	X		
~~Gidge, Kenneth N.~~ Schultz	X		
Abel, Richard M.	X		
~~McBeath, Rebecca Susan Clerk~~ Rung	X		
Bartlett, Christy D.	X		
Herbert, Christopher J.	X		
Van Houten, Constance	X		
~~Fargo, Kristina M.~~ McConnell	X		
Indruk, Greg L.	X		
Muscatel, Garrett D.	X		
Weston, Joyce	X		
Hunt, John B.	X		
~~Sanborn, Laurie J.~~ BURNS	X		
Osborne, Jason M.	X		
Costable, Michael	X		
Plumer, John R.	X		
Barnes, Arthur E.	X		
Potucek, John M.	X		
~~Warden, Mark~~ Spilane	X		
TOTAL VOTE: 20-0			

Rep. Muscatel, Graf. 12
March 8, 2019
2019-0906h
01/04

Amendment to HB 657

Amend the title of the bill by replacing it with the following:

AN ACT relative to prescription drugs under the managed care law.

Amend the bill by replacing all after the enacting clause with the following:

1 Managed Care Law; Prescription Drugs. Amend RSA 420-J:7-b, II through III to read as follows:

II. Every health benefit plan that provides prescription drug benefits shall maintain an expeditious exception process, not to exceed 48 hours, by which covered persons may obtain coverage for a medically necessary nonformulary prescription drug ***or for a nonformulary prescription drug that was available during the previous 12 months.*** The exception process shall begin when the prescribing provider has submitted a request with a clinical rationale for the exception to the health benefit plan. ***The exception process shall also begin when a covered person has submitted a non-clinical request for access to a drug approved by the federal Food and Drug Administration for treating a specific condition when such drug was available on the formulary during the previous 12 months.*** A prescription that requires an exception for coverage shall be considered approved if the exception process exceeds 48 hours.

II-a. No health benefit plan that provides prescription drug benefits and establishes the specific sequence in which prescription drugs for a medical condition are to be prescribed shall require failure on the same medication on more than one occasion for patients continuously enrolled in the plan. Nothing in this section shall be construed to prevent a health care provider from prescribing a medication to the same patient on more than one occasion, when he or she determines it is medically appropriate.

III. Every health plan that provides prescription drug benefits shall [~~notify~~] ***provide written notice in a conspicuous font and size to*** covered persons affected by deletions to the plan list or plan formulary, provide an explanation of the exception process by which a covered person can access nonformulary medically necessary prescription drugs, and provide a toll-free telephone number through which a covered person can request additional information. For purposes of this paragraph, covered persons affected by deletions to the plan list or plan formulary shall include those covered persons for whom the health plan has provided coverage for the deleted prescription drugs during the 12-month period immediately prior to the deletion. Upon notification

to covered persons, the health benefit plan shall allow at least 45 days before implementation of any formulary deletions; provided, however, that advance notice shall not be required if the federal Food and Drug Administration has determined that a prescription drug on the health benefit plan's formulary is unsafe. ***For purposes of this section, "conspicuous font and size" shall mean a font that is at least 12 point in size and in an easily legible font. If a covered person avails him or herself of the exception process as outlined in 420-J:7-b, II, the medication shall be covered by the health plan until there is a resolution of the exception process.***

2 Managed Care Law; Prescription Drugs. Amend RSA 420-J:7-b, IX(a) to read as follows:

IX.(a) Every health benefit plan that provides prescription drug benefits shall allow its covered persons to obtain an emergency prescription for up to a 72-hour supply of covered prescription drugs on the covered person's health benefit plan formulary ***or a prescription drug that was deleted from the formulary within the last 90 days*** in the event a prescription requires prior authorization ***or an exception*** by an insurance carrier and the prior authorization ***or exception*** has neither been approved nor denied and a pharmacist has determined the medication is essential as provided in RSA 318:47-i. Such reimbursement shall be according to the payment rates of the provider contract. If authorization ***or exception*** is subsequently denied, the carrier shall reimburse the pharmacist for the prescription as given based on the pro-rated amount they would have otherwise received under the terms of the provider contract.

3 Effective Date. This act shall take effect 60 days after its passage.

2019-0906h

AMENDED ANALYSIS

This bill clarifies the law regarding prescription drugs under the managed care law.

Sub-Committee Minutes

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 657

BILL TITLE: (New Title) relative to prescription drugs under the managed care law.

DATE: March 8, 2019

Subcommittee Members: Reps. Butler, Williams, McBeath, Gidge, Abel, Bartlett, Herbert, Van Houten, Fargo, Indruk, Muscatel, Weston, Hunt, Sanborn, J. Osborne, Costable, Plumer, Barnes, Potucek and Warden

Comments and Recommendations: Heidi Kroll to get new amendment. Amendment allows for exception process if someone knocked out of specific drug. When removed from formulary. Needs additional work by OLS. Holly had concern about continued access if just financial issue. Straw poll 6-0 in favor.

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 657

BILL TITLE: relative to the lowest cost option in the formulary under the managed care law.

DATE: 3-8-17

Subcommittee Members: Reps. Butler, Williams, McBeath, Gidge, Abel, Bartlett, Herbert, Van Houten, Fargo, Indruk, Muscatel, Weston, Hunt, Sanborn, J. Osborne, Costable, Plumer, Barnes, Potucek and Warden

Comments and Recommendations: Heidi Kroll to get new amendment
Amendment allows for exception process if Someone knocked out of specific drug. when removed from formulary. Needs additional work by OLS.
Holly had concern about continued access. if just financial issue.

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote: _____

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

_____ Amendment Adopted _____ Amendment Failed

Straw poll
6-0 in favor

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote: _____

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

_____ Amendment Adopted _____ Amendment Failed

Respectfully submitted,

Rep. _____
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 657

BILL TITLE: (New Title) relative to prescription drugs under the managed care law.

DATE: March 6, 2019

Subcommittee Members: Reps. Butler, Bartlett, Fargo, Muscatel, Weston, Hunt, Barnes and Potucek

Comments and Recommendations: Hold for lower costs options to be submitted by email by Friday March 8th.

Respectfully submitted,

Rep. Kristina Fargo
Subcommittee Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 657

BILL TITLE: relative to the lowest cost option in the formulary under the managed care law.

DATE: 3/6/19

Subcommittee Members: Reps. Butler, Williams, McBeath, Gidge, Abel, Bartlett, Herbert, Van Houten, Fargo, Indruk, Muscatel, Weston, Hunt, Sanborn, J. Osborne, Costable, Plumer, Barnes, Potucek and Warden

Comments and Recommendations:

Hold for lower cost options to be submitted by email by Friday March 8th

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote:

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote: ____

_____ Amendment Adopted _____ Amendment Failed

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote:

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote: ____

_____ Amendment Adopted _____ Amendment Failed

Respectfully submitted,

Rep. Kristina Fargo
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 657

BILL TITLE: (New Title) relative to prescription drugs under the managed care law.

DATE: February 21, 2019

Subcommittee Members: Reps. Butler, Bartlett, Fargo, Muscatel, Weston, Hunt, Barnes and Potucek

Comments and Recommendations: Hold for amendment from Rep. Butler.

Respectfully submitted,

Rep. Kristina Fargo
Subcommittee Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 657

BILL TITLE: relative to the lowest cost option in the formulary under the managed care law.

DATE: 2-21-19

Subcommittee Members: Reps. Butler, Williams, McBeath, Gidge, Abel, Bartlett, Herbert, Van Houten, Fargo, Indruk, Muscatel, Weston, Hunt, Sanborn, J. Osborne, Costable, Plumer, Barnes, Potucek and Warden

Comments and Recommendations:

hold for amendment from Rep. Butler

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote:

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

_____ Amendment Adopted _____ Amendment Failed

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote:

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

_____ Amendment Adopted _____ Amendment Failed

Respectfully submitted,

Rep. /Kristina Fargo
Subcommittee Chairman/Clerk

Hearing Minutes

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

PUBLIC HEARING ON HB 657

BILL TITLE: **(New Title) relative to prescription drugs under the managed care law.**

DATE: **February 19, 2019**

LOB ROOM: **302** **Time Public Hearing Called to Order:** **11:11 a.m.**

Time Adjourned: **11:35 a.m.**

Committee Members: **Reps. Butler, Williams, Abel, Herbert, Van Houten, Fargo, Indruk, Muscatel, Weston, Hunt, Sanborn, Barnes, Potucek and Warden**

Bill Sponsors:

Rep. Butler	**Rep. Marsh**	**Rep. Knirk**
Rep. Hennessey	**Sen. Sherman**	

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep. Ed Butler - Prime sponsor of the bill. Mandate within familiar lowest cost generic included issue of rebates can be part of negotiation ref. lowest cost generic to be included will put downward pressure on cost.

April Alexander, PCMA - Opposes the bill but not sure how to comply. Goal to help patient decide and drive to lowest cost in New Hampshire law reg. that patient get s lowest cost between contract amount or reimbursement amount or usual and customary if need exception, exception policy already in place.

***Holly Stevens, New Futures** - Supports the bill. Talked of patent with issue language - insurer could be in compliance today but not tomorrow because of fluctuation. Need to address or work in subcommittee.

Rep. Hunt: Which insurance is with problem? ANS: Could go back. Committee should find out? ANS: Advocated for self and got lowest. Competiveness among drug companies when approach PBM - may make deals? ANS: Could happen rebate comes in after fact.

Rep. Herbert: If bill passes, who would be asking PBM's and insurances to be enforced? ANS: Assumes insurance department.

Heidi Kroll, America's Health Insurance Plans (AHIP) - Opposes the bill but not to concept. Wants lowest cost options for formularies. Concern, how to define lowest cost option for member as pricing changes determined of what point in time does coupon factor in shouldn't have expensive burned or formulary because of coupon/cash - co-pay or negotiated price - which is involved?

Rep. Williams: Assume i don't know about coupon, would take into account? ANS: Would have to work on.

Rep. Hunt: Of lowest cost not or formulary, required to carry that away? ANS: Would work on.

Tyler Brannen, NH Insurance Department - No position. To better understand relationship between PBM, carrier, pharmacy can look at costs in different ways. Confusion - bill intends to give lowest cost, but needs to be determined. Bill would but new larger between PBM and manufacturer.

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

PUBLIC HEARING ON HB 657

BILL TITLE: relative to the lowest cost option in the formulary under the managed care law.

DATE: 2-19-19

ROOM: 302 **Time Public Hearing Called to Order:** 11:11

Time Adjourned: 11:35

(please circle if present)

Committee Members: Reps. Butler, Williams, McBeath, Gidge, Abel, Bartlett, Herbert, Van Houten, Fargo, Indruk, Muscatel, Weston, Hunt, Sanborn, J. Osborne, Costable, Plumer, Barnes, Potucek and Warden

Bill Sponsors:
Rep. Butler
Rep. Hennessey
Rep. Marsh
Sen. Sherman
Rep. Knirk

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

1. Rep. Ed Butler, prime sponsor
2. April Alexander - PCMA
* 3. Holly Stevens - New Futures
4. Heidi Kroll - America's Health Insurance Plans
5. Tyler Brannen - NH Ins. Department

HB 657

(1) Rep. Butler, prime sponsor
mandate w/in formulary - ~~lowest~~ cost generic included
issue of rebates can be part of negotiation
neg. lowest cost generic to be included - will put downward pressure on cost

(2) April Alexander - PCMA
PBMs - oppose, but not sure how to comply
goal to help patient decide + drive to lowest cost - in NH law
eg. that patient gets lowest cost
Does contract amt or reimbursement amount or usual + customary
if need exception, exception policy already in place

(3) Holly Stevens - New Futures
in support / written testimony
talked of patient with issue
language - insurer could be in compliance today but not tomorrow because of fluctuation - need to address
or work in subcommittee

Q - JH - which ins. co w/ problem?
A. could go back
Q - JH - com. should find out
A - advocated for self + got lowest

Q-JH - competitiveness among drug co when approach PBM - may make deals?
A - could happen, relate comes in after fact

Q-CH - if bill passes- who would be asking PBMs to ins co. to ~~be~~ enforced
A - assumes ins. dept.

---

(4) Heidi Knoll - America's Health Ins. Plans oppose, but not to concept - wants lowest cost options or formularies
concern - how to defini lowest cost option for member as pricing changes - determined at what pt. in time // does coupon factor in - shouldn't have expensive brand on formulary because of coupon/cash - co-pay or negotiated ~~to~~ price - which is involved?

Q-KW - assume if don't know about coupon, would take into acc't
A - would have to work on
Q - JH if lowest cost not on formulary, required to carry that drug.
A - would work on

HB 65?

(5) Tyler Brannen, Ins. Dept.
to better understand relationship betw.
PBM, carrier, pharmacy
can look at costs in different
ways
no position
confusion –
bill intends to give lowest cost,
but needs to be determined
bill would put new layer between
PBM + ~~inf~~ manufacturer
Q-KW – what can ins. dept
control? self funded?
A – reg. PBMs, ~~DH~~ several
departments involved (labor, etc.),
often doing same for
self-insured as for fully
insured
Q-KF – incentive + not offer
lowest cost?
A – complex – imbalance betw
some inc. co + PBMs (larger
vs. smaller)
Q-JH – require PBM to carry of
cheaper?
A – ~~JH~~ could

blue sheet –

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 657 Date 2-19-19

Committee Commerce & CA

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Rep Erin Hennessey			Grafton 1	✓	
Rep. William Marsh			Carroll 8	✓	
Lindsay Nadeau			Cigna		✓
PAULA ROGERS			ANTHEM		✓
Stefani Reardon			Harvard Pilgrim		✓
Richard Cohen			NHPA	✓	
Richard Moore			AARP		
Robert Mulligan			AARP		
Tim Isaak			AARP		
Sen. Tom Sherman			SD24	X	
Fran Wendelboe			NHIPA	X	

Testimony

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

Amend the bill by replacing all after the encacting clause with the following:

420-J:7-b Prescription Drugs.

I. (a) Every health benefit plan that provides prescription drug benefits is required to provide prospective enrollees, and covered persons, a description of the prescription drug benefit plan. Among the specific items that shall be included in the description are:

(1) The procedure a covered person must follow to obtain drugs and medications that are subject to a plan list or plan formulary.

(2) A description of the drug formulary and the plan's exception process.

(3) A description of the extent to which a covered person will be reimbursed for the cost of a drug that is not on a plan list or formulary.

(b) Health carriers shall provide upon request additional information to covered persons related to specific drugs that are not on the formulary.

II. Every health benefit plan that provides prescription drug benefits shall maintain an expeditious exception process, not to exceed 48 hours, by which covered persons may obtain coverage for a medically necessary nonformulary prescription drug or for a nonformulary prescription drug that was previously available during the plan year. The exception process shall begin when the prescribing provider has submitted a request with a clinical rationale for the exception to the health benefit plan ***or when a covered person has submitted a non-clinical request for continued access to a drug approved by the federal Food and Drug Administration for treating a specific condition when such drug was previously available on the formulary during the plan year***. A prescription that requires an exception for coverage shall be considered approved if the exception process exceeds 48 hours. II-a. No health benefit plan that provides prescription drug benefits and establishes the specific sequence in which prescription drugs for a medical condition are to be prescribed shall require failure on the same medication on more than one occasion for patients continuously enrolled in the plan. Nothing in this section shall be construed to prevent a health care provider from prescribing a medication to the same patient on more than one occasion, when he or she determines it is medically appropriate.

III. Every health plan that provides prescription drug benefits shall ***provide written notice in a non-conspicuous font and size to*** [~~notify~~] covered persons affected by deletions to the plan list or plan formulary, provide an explanation of the exception process by which a covered person can access nonformulary medically necessary prescription drugs, and provide a toll-free telephone number through which a covered person can request additional information. For

purposes of this paragraph, covered persons affected by deletions to the plan list or plan formulary shall include those covered persons for whom the health plan has provided coverage for the deleted prescription drugs during the 1[~~2~~]-month period immediately prior to the deletion. Upon notification to covered persons, the health benefit plan shall allow at least 45 days before implementation of any formulary deletions; provided, however, that advance notice shall not be required if the federal Food and Drug Administration has determined that a prescription drug on the health benefit plan's formulary is unsafe. ***For purposes of this section, "non-conspicious font and size" shall mean font that is at least 12 point in size and in an easily legible font such as Times New Roman. If a covered person avails him or herself of the exception process as outlined in 420-J:7-b(II), the medication shall be covered by the health plan until there is a resolution of the exception process.***

IV. Every health benefit plan that provides prescription drug benefits shall maintain, as part of its records, all of the following information, which shall be made available to the commissioner upon request: the complete drug formulary or formularies of the plan, if the plan maintains a formulary, including a list of the prescription drugs on the formulary of the plan by major therapeutic category with an indication of whether any drugs are preferred over the other drugs.

IV-a. Every health benefit plan that provides prescription drug benefits shall provide notice of deletions to the plan list or plan formulary to all covered persons at least annually.

IV-b. Every health benefit plan that provides prescription drug coverage shall also provide notice of additions to the plan list or formulary to all covered persons at least annually. However, the requirements of this paragraph shall not apply to any health benefit plan that adds prescription drugs to its plan list or formulary upon approval by the federal Food and Drug Association.

IV-c. (a) Beginning July 1, 2017, all health insurers, health maintenance organizations, health services corporations, medical services corporations, and preferred provider programs may, when requiring prior authorization for a prescription drug, use and accept the prior authorization paper forms or electronic standard described in this paragraph.

(b) Beginning December 31, 2017, all health insurers, health maintenance organizations, health services corporations, medical services corporations, and preferred provider programs shall, when requiring prior authorization for a prescription drug, use and accept only the prior authorization paper forms or electronic standard described in this paragraph.

(c) On or before March 1, 2017, the commissioner shall adopt rules, pursuant to RSA 541-A, specifying the contents and format of the uniform prior authorization paper forms and the electronic prior authorization standard, consistent with the requirements of this paragraph. In developing the paper forms and the electronic standard, the commissioner shall seek input from interested stakeholders, including, but not limited to, prescribers, pharmacists, carriers, and prescription benefits managers, and shall support adoption of nationally recognized standards for electronic prior authorization of prescription drugs, including those provided by the National Council for Prescription Drug Programs or an equivalent organization as available.

(d) The prior authorization paper forms adopted under this paragraph shall not exceed 2 pages in length.

(e) Nothing in this paragraph shall require a carrier or pharmacy benefits manager to use electronic prior authorization. A carrier or pharmacy benefits manager shall not require use of electronic prior authorization when:

(1) A pharmacist or prescriber lacks broadband Internet access;

(2) A pharmacist or prescriber has low patient volume;

(3) A pharmacist or prescriber has opted-out for a certain medical condition or for a patient request;

(4) A pharmacist or prescriber lacks an electronic medical record system;

(5) The electronic prior authorization interface does not provide for the pre-population of prescriber and patient information; or

(6) The electronic prior authorization interface requires an additional cost to the prescriber.

(f) Nothing in this section shall prohibit the use of prior authorization for prescription drug benefits.

(g) This section shall apply to RSA 420-J and shall not apply to the Medicaid managed care program under RSA 126-A:5, XIX.

V. Every health benefit plan that provides coverage for prescription drugs or devices, or administers such a plan, or which contracts with an entity providing such prescription drug coverage, including but not limited to pharmacy benefit manager companies, shall issue to covered persons a card or other technology containing uniform prescription drug information. The uniform prescription drug information card or technology shall include all of the fields required by the health insurance provider for claims processing in a clear, readable, and understandable manner on the card or other technology issued and shall include, at a minimum, the following information:

(a) The name or trademark logo of the insurer and, if another company administers the prescription benefit, the name or trademark logo of the benefit administrator.

(b) The covered person's name and identification number.

(c) All of the electronic transaction routing information required by the insurer or its benefit administrator in order for the pharmacy to electronically process a prescription claim, including but not limited to the BIN number labeled as such or the Processor Control Number labeled as such, or both.

VI. All subscriber health insurance cards issued after January 1, 2004 shall contain the information required under paragraph V.

VII. A new uniform prescription drug information card, as required under paragraph V, shall be issued by health benefit plan upon enrollment of new members and when reissuing a new card to current members when there is a change in the covered person's pharmacy coverage that affects data contained on the card.

VIII. Every health benefit plan that provides prescription drug benefits shall allow its covered persons to purchase an up-to-90-day supply of covered prescription drugs on the covered person's health benefit plan formulary at one time at a pharmacy of the insured's choice within the insurer's network, provided that the insured can demonstrate that such drug has been taken by the insured for a continuous period of one year and provided that such drug is not subject to the health benefit plan's utilization management, prior authorization, or pre-certification requirements. Controlled substances as identified by the United States Drug Enforcement Administration are exempt from this paragraph. Nothing in this paragraph shall be construed to limit the health benefit plan's ability to establish co-payments, coinsurance deductibles, or other member cost shares. A retail pharmacy dispensing a 90-day supply of covered prescription drugs under this paragraph shall comply with any specified terms, conditions, and reimbursement rate which the health benefit plan may require for mail order pharmacies that fill 90-day prescriptions.

IX. (a) Every health benefit plan that provides prescription drug benefits shall allow its covered persons to obtain an emergency prescription for up to a 72-hour supply of covered prescription drugs on the covered person's health benefit plan formulary ***or a precription drug that was deleted from the formulary within the last 90 days*** in the event a prescription requires prior authorization ***or an exception*** by an insurance carrier and the prior authorization ***or exception*** has neither been approved nor denied and a pharmacist has determined the medication is essential as provided in RSA 318:47-i. Such reimbursement shall be according to the payment rates of the provider contract. If authorization is subsequently denied, the carrier shall reimburse the pharmacist for the prescription as given based on the pro-rated amount they would have otherwise received under the terms of the provider contract.

(b) The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted:

(1) Agents when used for anorexia, weight loss, or weight gain.

(2) Agents when used to promote fertility.

(3) Agents when used for cosmetic purposes or hair growth.

(4) Agents when used for the symptomatic relief of cough and colds.

(5) Agents when used to promote smoking cessation.

(6) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

(7) Nonprescription drugs, except, in the case of pregnant women when recommended by or under the supervision of a physician, agents approved by the Food and Drug Administration

under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

(8) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

(9) Barbiturates.

(10) Benzodiazepines.

(11) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

X. (a) A pharmacy benefits manager or insurer shall require a contracted pharmacy to charge an enrollee or insured person the pharmacy's usual and customary price of filling the prescription or the contracted copayment, whichever is less.

(b) Once it has settled a claim for filling a prescription for an enrollee or insured person and notified the pharmacy of the amount the pharmacy benefits manager or insurer shall pay to the pharmacy for that prescription, the pharmacy benefits manager or insurer shall not lower the amount to be paid to the pharmacy by the pharmacy benefits manager or the insurer for such settled claim; provided, however, that this paragraph shall not apply if the claim was submitted fraudulently or with inaccurate or misrepresented information.

(c) The commissioner shall adopt rules under RSA 541-A to implement this paragraph. Such rules shall include procedures for addressing complaints, provisions for enforcement, the receipt of complaints referred to the insurance department under RSA 318:47-h, III(b), and for reporting to the board of pharmacy on the status of complaints referred.

February 19, 2018

The Honorable Edward Butler, Chair
House Commerce and Consumer Affairs Committee
Legislative Office Building Room 302
Concord, NH 03301

Re: New Futures' support of HB 657

Dear Chairman Butler and Members of the Committee:

New Futures appreciates the opportunity to testify in support of HB 657, which would require health plans to include on the formulary the drug with the lowest cost option for the insured. New Futures is a nonpartisan, nonprofit organization that advocates, educates and collaborates to improve the health and wellness of all New Hampshire residents. In this role, we work extensively with policy makers, health care providers and families to increase access to quality, affordable health care throughout the Granite State. In recent years, with the increasing cost of pharmaceutical drug prices, including generics that have been on the market for decades, transparency in the pharmaceutical industry is of concern to New Futures.

Last summer, I participated in the HB 1418 Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs (Commission). Although the Commission heard testimony from many stakeholders, it did not have enough time to complete its study. The Commission was not able to come to a consensus around any legislative recommendations; however, individual Commission members did make suggestions for legislative change. One thing that was clear from the testimony is that increasing drug prices are not the result of any one entity type (i.e. manufacturers, PBM, insurers, etc.), but due to what is going on in the entire system. The problem is, the system is very opaque, and no one can see what is truly causing the skyrocketing prices.

One of the legislative suggestions that resulted from the Commission was that health insurance plans would be required to include on their formularies the lowest cost option for the insured. This bill is being offered as a direct result of testimony received during the HB 1418 Commission. A consumer testified that she was on a certain medication. She stated that it was removed from the formulary and was replaced by a drug that had a higher out of pocket cost to her. Not only was this medication a higher cost to her, it was a higher cost to her insurer. The medication she had been on cost much less than the one she was now required to be on. She was able to advocate for herself and have the insurer cover the less expensive medication. The thing that doesn't make sense is why the insurer stopped covering the medication in the first place, replacing it with a medication that was more expensive for everyone.

To protect Granite Staters from paying high out of pocket costs when there are cheaper alternatives, this legislation is necessary. However, as drafted, it could pose some issues due to the constant fluctuation in the price of generic drugs. An insurer could be in compliance today and out of compliance tomorrow when the prices change. This may require the insurers to constantly change their formularies which is not good for consumers or the insurers. To make this legislation

workable, New Futures suggest working with the insurers to find out the best way to implement the intent of this bill.

Making sure the lowest cost medication option for all medical conditions, it extremely important to limit the out of pocket cost to consumers and to keep health insurance premiums down. HB 657 is one step and one bill among many this session that will lead to greater transparency and lower cost options for New Hampshire's residents. For those reasons, New Futures urges the Committee vote HB 657 ought to pass.

Please do not hesitate to contact me if you have any questions.

Respectfully submitted,

Holly A. Stevens, Esq.
Health Policy Coordinator

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

Amend the bill by replacing all after the encacting clause with the following:

420-J:7-b Prescription Drugs.

I. (a) Every health benefit plan that provides prescription drug benefits is required to provide prospective enrollees, and covered persons, a description of the prescription drug benefit plan. Among the specific items that shall be included in the description are:

(1) The procedure a covered person must follow to obtain drugs and medications that are subject to a plan list or plan formulary.

(2) A description of the drug formulary and the plan's exception process.

(3) A description of the extent to which a covered person will be reimbursed for the cost of a drug that is not on a plan list or formulary.

(b) Health carriers shall provide upon request additional information to covered persons related to specific drugs that are not on the formulary.

II. Every health benefit plan that provides prescription drug benefits shall maintain an expeditious exception process, not to exceed 48 hours, by which covered persons may obtain coverage for a medically necessary ***or a lower cost option*** nonformulary prescription drug. The exception process shall begin when the prescribing provider has submitted a request with a clinical rationale for the exception to the health benefit plan ***or when a covered person has submitted a request with information regarding a lower cost option***. A prescription that requires an exception for coverage shall be considered approved if the exception process exceeds 48 hours. ***For the purposes of this section, "lower cost option" shall mean a prescription drug that has a lower cost than any prescription drug on the formulary based on the maximum allowable cost or other allowable payment maximum as determind in the provider contract with an in-network pharmacy among drugs appproved by the federal Food and Drug Administration for treating a specific condition. The lower cost option shall be based on a 30 day supply.***

II-a. No health benefit plan that provides prescription drug benefits and establishes the specific sequence in which prescription drugs for a medical condition are to be prescribed shall require failure on the same medication on more than one occasion for patients continuously enrolled in the plan. Nothing in this section shall be construed to prevent a health care provider from prescribing a medication to the same patient on more than one occasion, when he or she determines it is medically appropriate.

III. Every health plan that provides prescription drug benefits shall ***provide written notice in a conspicuous font and size to*** [~~notify~~] covered persons affected by deletions to the plan list or plan formulary, provide an explanation of the exception process by which a covered person can access nonformulary medically necessary prescription drugs, and provide a toll-free telephone number through which a covered person can request additional information. For purposes of this paragraph, covered persons affected by deletions to the plan list or plan formulary shall include those covered persons for whom the health plan has provided coverage for the deleted prescription drugs during the 1[~~2~~]-month period immediately prior to the deletion. Upon notification to covered persons, the health benefit plan shall allow at least 45 days before implementation of any formulary deletions; provided, however, that advance notice shall not be required if the federal Food and Drug Administration has determined that a prescription drug on the health benefit plan's formulary is unsafe. ***For purposes of ths section, "conspicious font and size" shall mean font that is at least 12 point in size and in an easily legible font such as Times New Roman. If a covered person avails him or herself of the exception process as outlined in 420-J:7-b(II), the medication shall be covered by the health plan until there is a resolution of the exception process.***

IV. Every health benefit plan that provides prescription drug benefits shall maintain, as part of its records, all of the following information, which shall be made available to the commissioner upon request: the complete drug formulary or formularies of the plan, if the plan maintains a formulary, including a list of the prescription drugs on the formulary of the plan by major therapeutic category with an indication of whether any drugs are preferred over the other drugs.

IV-a. Every health benefit plan that provides prescription drug benefits shall provide notice of deletions to the plan list or plan formulary to all covered persons at least annually.

IV-b. Every health benefit plan that provides prescription drug coverage shall also provide notice of additions to the plan list or formulary to all covered persons at least annually. However, the requirements of this paragraph shall not apply to any health benefit plan that adds prescription drugs to its plan list or formulary upon approval by the federal Food and Drug Association.

IV-c. (a) Beginning July 1, 2017, all health insurers, health maintenance organizations, health services corporations, medical services corporations, and preferred provider programs may, when requiring prior authorization for a prescription drug, use and accept the prior authorization paper forms or electronic standard described in this paragraph.

(b) Beginning December 31, 2017, all health insurers, health maintenance organizations, health services corporations, medical services corporations, and preferred provider programs shall, when requiring prior authorization for a prescription drug, use and accept only the prior authorization paper forms or electronic standard described in this paragraph.

(c) On or before March 1, 2017, the commissioner shall adopt rules, pursuant to RSA 541-A, specifying the contents and format of the uniform prior authorization paper forms and the electronic prior authorization standard, consistent with the requirements of this paragraph. In developing the paper forms and the electronic standard, the commissioner shall seek input from interested stakeholders, including, but not limited to, prescribers, pharmacists, carriers, and

prescription benefits managers, and shall support adoption of nationally recognized standards for electronic prior authorization of prescription drugs, including those provided by the National Council for Prescription Drug Programs or an equivalent organization as available.

(d) The prior authorization paper forms adopted under this paragraph shall not exceed 2 pages in length.

(e) Nothing in this paragraph shall require a carrier or pharmacy benefits manager to use electronic prior authorization. A carrier or pharmacy benefits manager shall not require use of electronic prior authorization when:

(1) A pharmacist or prescriber lacks broadband Internet access;

(2) A pharmacist or prescriber has low patient volume;

(3) A pharmacist or prescriber has opted-out for a certain medical condition or for a patient request;

(4) A pharmacist or prescriber lacks an electronic medical record system;

(5) The electronic prior authorization interface does not provide for the pre-population of prescriber and patient information; or

(6) The electronic prior authorization interface requires an additional cost to the prescriber.

(f) Nothing in this section shall prohibit the use of prior authorization for prescription drug benefits.

(g) This section shall apply to RSA 420-J and shall not apply to the Medicaid managed care program under RSA 126-A:5, XIX.

V. Every health benefit plan that provides coverage for prescription drugs or devices, or administers such a plan, or which contracts with an entity providing such prescription drug coverage, including but not limited to pharmacy benefit manager companies, shall issue to covered persons a card or other technology containing uniform prescription drug information. The uniform prescription drug information card or technology shall include all of the fields required by the health insurance provider for claims processing in a clear, readable, and understandable manner on the card or other technology issued and shall include, at a minimum, the following information:

(a) The name or trademark logo of the insurer and, if another company administers the prescription benefit, the name or trademark logo of the benefit administrator.

(b) The covered person's name and identification number.

(c) All of the electronic transaction routing information required by the insurer or its benefit administrator in order for the pharmacy to electronically process a prescription claim, including but not limited to the BIN number labeled as such or the Processor Control Number labeled as such, or both.

VI. All subscriber health insurance cards issued after January 1, 2004 shall contain the information required under paragraph V.

VII. A new uniform prescription drug information card, as required under paragraph V, shall be issued by health benefit plan upon enrollment of new members and when reissuing a new card to current members when there is a change in the covered person's pharmacy coverage that affects data contained on the card.

VIII. Every health benefit plan that provides prescription drug benefits shall allow its covered persons to purchase an up-to-90-day supply of covered prescription drugs on the covered person's health benefit plan formulary at one time at a pharmacy of the insured's choice within the insurer's network, provided that the insured can demonstrate that such drug has been taken by the insured for a continuous period of one year and provided that such drug is not subject to the health benefit plan's utilization management, prior authorization, or pre-certification requirements. Controlled substances as identified by the United States Drug Enforcement Administration are exempt from this paragraph. Nothing in this paragraph shall be construed to limit the health benefit plan's ability to establish co-payments, coinsurance deductibles, or other member cost shares. A retail pharmacy dispensing a 90-day supply of covered prescription drugs under this paragraph shall comply with any specified terms, conditions, and reimbursement rate which the health benefit plan may require for mail order pharmacies that fill 90-day prescriptions.

IX. (a) Every health benefit plan that provides prescription drug benefits shall allow its covered persons to obtain an emergency prescription for up to a 72-hour supply of covered prescription drugs on the covered person's health benefit plan formulary ***or a precription drug that was deleted from the formulary within the last 90 days*** in the event a prescription requires prior authorization ***or an exception*** by an insurance carrier and the prior authorization ***or exception*** has neither been approved nor denied and a pharmacist has determined the medication is essential as provided in RSA 318:47-i. Such reimbursement shall be according to the payment rates of the provider contract. If authorization is subsequently denied, the carrier shall reimburse the pharmacist for the prescription as given based on the pro-rated amount they would have otherwise received under the terms of the provider contract.

(b) The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted ***unless it is a prescription drug that was deleted from the formulary within the last 90 days***:

(1) Agents when used for anorexia, weight loss, or weight gain.

(2) Agents when used to promote fertility.

(3) Agents when used for cosmetic purposes or hair growth.

(4) Agents when used for the symptomatic relief of cough and colds.

(5) Agents when used to promote smoking cessation.

(6) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

(7) Nonprescription drugs, except, in the case of pregnant women when recommended by or under the supervision of a physician, agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

(8) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

(9) Barbiturates.

(10) Benzodiazepines.

(11) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

X. (a) A pharmacy benefits manager or insurer shall require a contracted pharmacy to charge an enrollee or insured person the pharmacy's usual and customary price of filling the prescription or the contracted copayment, whichever is less.

(b) Once it has settled a claim for filling a prescription for an enrollee or insured person and notified the pharmacy of the amount the pharmacy benefits manager or insurer shall pay to the pharmacy for that prescription, the pharmacy benefits manager or insurer shall not lower the amount to be paid to the pharmacy by the pharmacy benefits manager or the insurer for such settled claim; provided, however, that this paragraph shall not apply if the claim was submitted fraudulently or with inaccurate or misrepresented information.

(c) The commissioner shall adopt rules under RSA 541-A to implement this paragraph. Such rules shall include procedures for addressing complaints, provisions for enforcement, the receipt of complaints referred to the insurance department under RSA 318:47-h, III(b), and for reporting to the board of pharmacy on the status of complaints referred.

Bill as Introduced

HB 657 - AS INTRODUCED

2019 SESSION

19-0801
01/03

HOUSE BILL ***657***

AN ACT relative to the lowest cost option in the formulary under the managed care law.

SPONSORS: Rep. Butler, Carr. 7; Rep. Marsh, Carr. 8; Rep. Knirk, Carr. 3; Rep. Hennessey, Graf. 1; Sen. Sherman, Dist 24

COMMITTEE: Commerce and Consumer Affairs

ANALYSIS

This bill requires health plans offering prescription drug benefits under the managed care law to include on the formulary the drug with the lowest cost option for the insured.

This bill is a result of the commission to study greater transparency in pharmaceutical costs and rebate programs established in 2018, 350.

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

19-0801
01/03

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Nineteen

AN ACT relative to the lowest cost option in the formulary under the managed care law.

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

1 Managed Care; Prescription Drugs. Amend RSA 420-J:7-b, III to read as follows:

III.*(a)* Every health plan that provides prescription drug benefits shall notify covered persons affected by deletions to the plan list or plan formulary, provide an explanation of the exception process by which a covered person can access nonformulary medically necessary prescription drugs, and provide a toll-free telephone number through which a covered person can request additional information. For purposes of this paragraph, covered persons affected by deletions to the plan list or plan formulary shall include those covered persons for whom the health plan has provided coverage for the deleted prescription drugs during the 12-month period immediately prior to the deletion. Upon notification to covered persons, the health benefit plan shall allow at least 45 days before implementation of any formulary deletions; provided, however, that advance notice shall not be required if the federal Food and Drug Administration has determined that a prescription drug on the health benefit plan's formulary is unsafe.

(b) Every health plan that provides prescription drug benefits shall include on the formulary the drug with the lowest cost option for the member, among drugs approved by the federal Food and Drug Administration for treating a specific condition. The lowest cost option shall include package sizing, administration, and dispensing methods. If a carrier uses a third party to administer a prescription drug benefit, such as a pharmacy benefit manager or similar entity, this formulary requirement shall also apply to drugs with a lower maximum allowable cost when there is no cost difference for the member.

2 Effective Date. This act shall take effect 60 days after its passage.