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## NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

### AN ACT CONCERNING PRESCRIPTION DRUG COSTS

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*\*Sponsored by Rep. Tom. Oliverson, M.D. (TX)*

*\*Co-Sponsored by Sen. Dan "Blade" Morrish (LA)*

*\*Discussion-Draft as of ~~June~~ November 11<sup>th</sup>, 2019. To be discussed during the Health Insurance and Long Term Care Issues Committee on ~~December~~ July 11<sup>th</sup>, 2019.*

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#### **Section 1. Title**

This Act shall be known as the [State] Health Care Cost Transparency Act.

#### **Section 2. Purpose**

The purpose of this Act is to promote prescription drug price transparency and cost control.

#### **Section 3. Definitions**

"Board of Pharmacy" or "board" means the [State] Board of Pharmacy.

"Commissioner" means the Insurance Commissioner.

"Department" means the Insurance Department.

"Director" means the Medicaid Director.

"Drug" means (A) articles recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States or official National Formulary, or any supplement to any of them; (B) articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in humans or other animals; (C) articles, other than food, intended to affect the structure or any function of the body of humans or any other animal; and (D) articles intended for use as a component of any articles specified in this subdivision; but shall not include devices or their components, parts or accessories;

"Health care plan" means any individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by a healthcare insurer in this state.

"Health carrier" or "Health insurer" means an insurance company, a health maintenance organization, or a hospital and medical service corporation.

"Net spending" means the cost of prescription drugs minus any discounts that lowers the price of the drugs, including, but not limited to, rebates, fees, retained price protections, retail pharmacy network spread, and dispensing fees.

"Pharmacist services" means products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy.

"Pharmacy benefits manager" means any person that administers the prescription drug, prescription device, pharmacist services or prescription drug and device and pharmacist services portion of a health care plan offered in the state on behalf of a [HEALTH CARRIER/INSURER].

"Rebate" means any discount or concession which affects the price of a prescription drug to a pharmacy benefits manager or health [CARRIER/INSURER] for a prescription drug manufactured by the pharmaceutical manufacturer.

"Specialty drug" means a prescription drug outpatient specialty drug covered under Medicare Part D program established pursuant to Public Law 108-73, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as amended from time to time, that exceeds the specialty tier cost threshold established by the Centers for Medicare and Medicaid Services.

"Utilization management" means a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings.

“Wholesale acquisition cost” means, with respect to a pharmaceutical drug or biological product, the manufacturer's list price for the pharmaceutical drug or biological product to wholesalers or direct purchasers in the United States for the most recent month for which the information is available, as reported in wholesale price guides or other publications of pharmaceutical drug or biological product pricing data, not including any rebates, prompt pay or other discounts, or other reductions in price.

#### **Section 4. Disclosure of prescription drug pricing information.**

(a)(1) Not later than January 1, 2020, and annually thereafter, each drug manufacturer shall submit a report to the [INSURANCE COMMISSIONER] no later than the fifteenth day of January, April, July, and October with the current wholesale acquisition cost information for the United States Food and Drug Administration approved drugs sold in or into the state by that manufacturer.

(2) The commissioner shall develop a website to contain prescription drug price information submitted pursuant to subsection (a)(1) of this section. The website shall be made available on the [INSURANCE DEPARTMENT'S] website with a dedicated link that is prominently displayed on the home page, or by a separate easily identifiable internet address.

(b)(1) Not more than thirty days after an increase in wholesale acquisition cost of ~~fifty~~sixty percent or greater over the preceding five calendar years or fifteen percent or greater in the preceding ~~twelve months~~ calendar year for a drug with a wholesale acquisition cost of ~~one hundred~~ seventy dollars or more for a thirty-day supply, a pharmaceutical drug manufacturer shall submit a report to the [COMMISSIONER OF INSURANCE]. The report shall contain the following information:

(A) Name of the product;

(B) Whether the drug is a brand name or a generic;

(C) The effective date of the change in wholesale acquisition cost;

(D) Aggregate, company-level research and development costs for the prior calendar year;

(E) The name of each of the manufacturer's prescription drugs that was approved by the federal Food and Drug Administration in the previous five calendar years; ~~and~~

(F) The name of each of the manufacturer's prescription drugs that lost patent exclusivity in the United States in the previous five calendar years; and

(G) A statement of rationale regarding the factor or factors that caused the increase in the wholesale acquisition cost.

(2) The quality and types of information and data that a pharmaceutical manufacturer submits to the commissioner pursuant to this subsection shall be consistent with the quality and types of information and data that the manufacturer includes in their annual consolidated report on Securities and Exchange Commission Form 10-K or any other public disclosure.

(3) Within sixty days of receipt, the commissioner shall publish the report on the [INSURANCE DEPARTMENT'S] prescription drug price information website developed pursuant to subsection (a)(2) this section.

(c) A manufacturer shall notify the commissioner in writing if it is introducing a new prescription drug to market at a wholesale acquisition cost that exceeds the threshold set for a specialty drug under the Medicare Part D program. The manufacturer shall provide the written notice ~~within three calendar days~~ biannually on January 1 and July 1 following the release of the drug in the commercial market. A manufacturer may make the notification pending approval by the U.S. Food and Drug Administration (FDA) if commercial availability is expected within three calendar days following the approval.

(d) The commissioner may adopt regulations to implement the provisions of this section.

#### **Section 5. Disclosure of pharmacy benefit management information.**

(a)(1) Not later than February 1, 2020, and annually thereafter, each pharmacy benefits manager shall file a report with the commissioner. The report shall contain the following information for the immediately preceding calendar year:

(A) The aggregated rebates, fees, price protection payments, and any other payments collected from pharmaceutical manufacturers;

(B) The aggregated dollar amount of rebates, price protection payments, fees and any other payments collected from pharmaceutical manufacturers that were passed to health [CARRIERS/INSURERS];

(C) The aggregated dollar amount of rebates, price protection payments, fees and any other payments collected from pharmaceutical manufacturers that were passed to enrollees at the point of sale; and

(D) The aggregated dollar amount of rebates, price protection payments, fees and any other payments collected from pharmaceutical manufacturers that were retained as revenue by the pharmacy benefit manager.

(2) Reports submitted by pharmacy benefit managers shall not disclose the identity of a specific health benefit plan or enrollee, the prices charged for specific drugs or classes of drugs, or the amount of any rebates or fees provided for specific drugs or classes of drugs.

(3) Within sixty days of receipt, the commissioner shall publish the report on the [INSURANCE DEPARTMENT'S] prescription drug price information website developed pursuant to subsection (a)(2) of section (41) of this Act. For any pharmacy benefit manager with fewer than five (5) clients, the commissioner shall aggregate all the collected data and publish the aggregated data from all reports for that year required by this section in an appropriate location on the department's internet website. The data from all of the reports must be published in a manner that does not disclose or tend to disclose proprietary or confidential information of any pharmacy benefit manager.

(b) The commissioner may adopt regulations to implement the provisions of this section.

### **Section 6. Disclosure of health [CARRIER/INSURER] spending information.**

(a)(1) Not later than February 1, 2020, and annually thereafter, each health [CARRIER/INSURER] shall submit a report to the commissioner. The report shall contain the following information for the immediately preceding calendar year:

(A) The names of the twenty-five most frequently prescribed prescription drugs across all plans;

(B) Percent increase in annual net spending for prescription drugs across all plans taking into account all rebates, discounts, and negotiated price concessions;

(C) Percent increase in premiums that were attributable to prescription drugs across all plans taking into account all rebates, discounts, and negotiated price concessions;

(D) Percentage of specialty prescription drugs with utilization management requirements across all plans;

(E) Premium reductions that were attributable to specialty drug utilization management.

(F) The number of requests for exceptions to the health benefit plan's formulary approved and denied.

(G) The number and rate of pharmacy claims transactions approved and rejected due to a prior authorization or other utilization management requirements, such as step therapy.

(E)(H) The percentage of enrollees who do not fill a prescription for an alternative therapy within 60-days of a denial of a requires for an exception and the percentage of enrollees who do not fill a prescription for an alternative therapy within 60-days of an initial rejection of a pharmacy claim transaction pursuant to a prior authorization or other utilization management requirement.

(2) Within sixty days of receipt, the commissioner shall publish the report on the [INSURANCE DEPARTMENT'S] prescription drug price information website developed pursuant to subsection (a)(2) of section (41) of this Act. For any health [CARRIER/INSURER] with an affiliated pharmacy benefit manager with fewer than five (5) clients, the commissioner shall aggregate all the collected data and publish the aggregated data from all reports for that year required by this section in an appropriate location on the department's internet website. The data from ~~all of all~~ the reports must be published in a manner that does not disclose ~~or tend to disclose~~ proprietary or confidential information of any health [CARRIER/INSURER].

(b) Reports submitted by [CARRIERS/INSURERS] shall not disclose the identity of a specific health benefit plan or the prices charged for specific drugs or classes of drugs.

(c) The commissioner ~~may~~ shall adopt regulations to implement the provisions of this section.

**Section 7. Severability**

If any provisions of this Act or the application of this Act to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provision or application, and to this end, the provisions of this Act are declared severable.

**Section 8. Effective Date**

This Act is effective immediately.