

HOUSE No. 2197

By Representative Marzilli of Arlington and Senator Montigny, joint petition of J. James Marzilli, Jr., and others for legislation to regulate and control the costs of health care in the Commonwealth. Public Health.

The Commonwealth of Massachusetts

PETITION OF:

J. James Marzilli, Jr.	Susan C. Fargo
William N. Brownsberger	David B. Sullivan
Steven J. D'Amico	Michael E. Festa
John P. Fresolo	Elizabeth A. Malia
Denise Provost	Alice K. Wolf
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In the Year Two Thousand and Seven.

AN ACT CONTROLLING HEALTH CARE COSTS.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

- 1 SECTION 1. Chapter 111 of the General Laws is hereby
- 2 amended by inserting after section 4L the following sections:—
- 3 Section 4M. The department shall, subject to appropriation,
- 4 establish a chronic disease self-management program. The pro-
- 5 gram shall support coordinated strategies to provide patients and
- 6 their families with education and support to increase skills and
- 7 confidence and empower patients to manage chronic conditions as
- 8 active partners in their own care.
- 9 The department shall provide pilot demonstration project grants
- 10 to non-profit community organizations to implement a variety of
- 11 chronic disease self-management approaches. Grants shall focus
- 12 on providing assistance in diverse settings that focus on under-
- 13 served populations and racial and ethnic minority populations.

14 No more than two years following the start of the initial pilot
15 demonstration projects, the department shall evaluate the pilot
16 demonstration projects. Based on the evaluations, the department
17 shall develop a comprehensive statewide plan to implement
18 chronic disease self management programs throughout the com-
19 monwealth. The plan shall be filed with the committees on public
20 health, health care financing and ways and means.

21 Section 4N. (a) The department shall develop, implement, and
22 promote an evidence-based outreach and education program
23 designed to provide information and education on the therapeutic
24 and cost-effective utilization of prescription drugs to physicians,
25 pharmacists, and other health care professionals authorized to pre-
26 scribe and dispense prescription drugs. In developing the acad-
27 emic detailing program the department shall consult with
28 physicians, pharmacists, private insurers, hospitals, pharmacy
29 benefit managers, the Masshealth drug utilization review board,
30 and the University of Massachusetts Medical School. The pro-
31 gram shall include the following elements:

32 (1) The opportunity for physicians, pharmacists and nurses
33 under contract with the program to conduct face-to-face visits
34 with prescribers, utilizing evidence-based materials and bor-
35 rowing methods from behavioral science, educational theory and
36 where appropriate, pharmaceutical industry data and outreach
37 techniques. To the extent possible, the program shall inform pre-
38 scribers about drug marketing that is intended to circumvent com-
39 petition from generic or other therapeutically equivalent
40 pharmaceutical alternatives or other evidence-based treatment
41 options.

42 (2) Outreach to physicians and other health care practitioners
43 who participate in MassHealth, the Prescription Advantage pro-
44 gram, the Commonwealth Care Health Insurance Program, and
45 other publicly funded, contracted or subsidized health care pro-
46 grams in the commonwealth, to academic medical centers, and to
47 other prescribers

48 (b) The program shall be made available to private payors on a
49 subscription basis.

50 (c) While recognizing the particular geographic and demo-
51 graphic characteristics of the commonwealth, the program shall be

52 modeled where practicable on the Pennsylvania PACE/Harvard
53 University Independent Drug Information Service. The depart-
54 ment shall, to the extent possible, also utilize or incorporate into
55 its program other independent educational resources or models
56 proven effective in promoting high quality, evidenced-based, cost-
57 effective information regarding the effectiveness and safety of
58 prescription drugs, including but not limited to (1) the Academic
59 Detailing Program of the University of Vermont College of Medi-
60 cine Area Health Education Centers, (2) the Oregon Health and
61 Science University Evidence-based Practice Center's Drug Effec-
62 tiveness Review project, and (3) the North Carolina evidence-
63 based peer to peer education program outreach program.

64 (d) The department shall promulgate regulations as necessary to
65 implement this Section in accordance with chapter 30A no later
66 than January 1, 2008, and shall begin implementing the program
67 no later than July 1, 2008.

68 (e) The department is authorized to establish and collect fees
69 for subscriptions and contracts with private payors and to seek
70 funding from nongovernmental health access foundations and
71 undesignated drug litigation settlement funds associated with
72 pharmaceutical marketing and pricing practices.

1 SECTION 2. Chapter 111 of the General Laws is hereby further
2 amended by inserting after section 51G the following section:—

3 Section 51H. The department shall establish emergency room
4 patient flow management standards for acute care hospitals. The
5 standards shall require each acute care hospital with an emergency
6 department to evaluate its elective surgical procedure scheduling
7 policy to determine if scheduling changes would reduce over-
8 crowding in the hospital's emergency department. The department
9 shall by regulation define the minimum requirements of the evalu-
10 ation required by this section.

11 The department shall require a hospital to change its elective
12 surgical procedure scheduling policy if the evaluation demon-
13 strates that the change would significantly reduce emergency
14 department overcrowding or reduce waiting time for emergency
15 services. The department may deny the renewal of a hospital
16 license pursuant to section 51 for violation of a requirement of
17 this section.

18 The department shall annually report on the effectiveness of
19 this section on reducing emergency room overcrowding,
20 improving health quality, and saving costs.

1 SECTION 3. Chapter 111 of the General Laws is hereby further
2 amended by inserting after section 70G the following section:—

3 Section 70H. (a) As used in this section, unless the context
4 otherwise indicates, the following terms shall have the following
5 meanings:—

6 “Carrier”, an insurer licensed or otherwise authorized to
7 transact accident and health insurance under chapter 175; a non-
8 profit hospital service corporation organized under chapter 176A;
9 a non-profit medical service corporation organized under
10 chapter 176B; a health maintenance organization organized under
11 chapter 176G, or an organization entering into a preferred provider
12 arrangement under chapter 176I.

13 “Administrator”, any person who receives or collects charges,
14 contributions or premiums for, or adjusts or settles claims in con-
15 nection with any type of health benefit provided under the plan as
16 an alternative to insurance.

17 “Commercial purpose”, advertising, marketing, promotion, or
18 any similar activity that is used or intended to be used to influence
19 sales or the market share of a pharmaceutical drug, to influence or
20 elevate the prescribing behavior of a prescriber, market prescrip-
21 tion drugs to individuals or to elevate the effectiveness of a pro-
22 fessional pharmaceutical detailing sales force.

23 “De-identified”, information that cannot be used to directly or
24 indirectly identify the patient or the prescriber. Information that
25 may identify the patient or prescriber includes a person’s name,
26 address, telephone number, facsimile number, electronic mail
27 address, photograph or likeness, account, credit card, medical
28 record, social security number, or any other unique number, char-
29 acteristic, code or information which is likely to lead to the identi-
30 fication of the patient or prescriber.

31 “Electronic transmission intermediary”, an entity that provides
32 the infrastructure that connects the computer systems or other
33 electronic devices used by health care practitioners, prescribers,
34 pharmacies, health care facilities and pharmacy benefit managers,

35 carriers, administrators and agents and contractors of those
36 persons and entities in order to facilitate the secure transmission
37 of an individual's prescription drug order, refill, authorization
38 request, claim, payment or other prescription drug information.

39 "Health care facility", a licensed facility, institution or entity
40 licensed that offers health care to persons in the commonwealth,
41 including a health care provider, home health care provider, hos-
42 pice program and a pharmacy.

43 "Health care practitioner", a person licensed to provide or oth-
44 erwise lawfully providing health care or a partnership or corpora-
45 tion made up of those persons or an officer, employee, agent or
46 contractor of that person acting in the course and scope of
47 employment, agency or contract related to or supportive of the
48 provision of health care to individuals.

49 "Health plan", a health plan providing prescription drug cov-
50 erage as authorized under the federal Medicare Prescription Drug,
51 Improvement and Modernization Act of 2003, Public Law 108-
52 173.

53 "Individual", a natural person who is the subject of prescription
54 drug information.

55 "Pharmacy", any retail drug business registered by the board of
56 registration in pharmacy in accordance with section 39 of
57 chapter 112 that is authorized to dispense controlled substances,
58 including a retail drug businesses as defined in section 1 of
59 chapter 94C and a mail order pharmacy.

60 "Pharmacy benefits manager", an entity that performs phar-
61 macy benefits management. "Pharmacy benefits manager"
62 includes a person or entity acting for a pharmacy benefits manager
63 in a contractual or employment relationship in the performance of
64 pharmacy benefits management for a covered entity and includes
65 mail service pharmacy.

66 "Prescriber", a person who is licensed, registered or otherwise
67 authorized to prescribe and administer drugs in the course of pro-
68 fessional practice.

69 "Prescription drug information", information concerning pre-
70 scription drugs which under federal law, is required, prior to being
71 dispensed or delivered, to be labeled "Caution: Federal law pro-
72 hibits dispensing without prescription" or is required by an applic-

73 able federal or state law or rule to be dispensed on prescription
74 only or is restricted to use by practitioners only, and includes
75 lawful written or oral order of a practitioner for a drug or device,
76 issued on a prescription form or by electronic transmission.

77 “Prescription drug information intermediary”, a person or entity
78 that communicates, facilitates or participates in the exchange of
79 prescription drug information regarding an individual or a pre-
80 scriber. “Prescription drug information intermediary” includes, but
81 shall not be limited to, a pharmacy benefits manager, a health
82 plan, an administrator and an electronic transmission interme-
83 diary.

84 “Regulated transaction”, a prescription for a drug that is written
85 by a prescriber within the commonwealth or that is dispensed
86 within the commonwealth.

87 (b) With regard to a regulated transaction, a prescriber, carrier,
88 pharmacy, or prescription drug information intermediary may not
89 license, use, sell, transfer or exchange for value, for any commer-
90 cial purpose, prescription drug information that identifies directly
91 or indirectly the individual or the prescriber except if expressly
92 permitted as a regulated transaction that is allowed under subsec-
93 tion (c).

94 (c) The following regulated transactions are allowed and are
95 not subject to the prohibitions of this section:—

96 (1) transfers of prescription drug information, including identi-
97 fication of the individual and prescriber, as required under the
98 chapter 94C;

99 (2) the dispensing of prescription drugs to an individual or the
100 individual's authorized representative, the transmission of pre-
101 scription drug information between a prescriber and a pharmacy
102 or other health care practitioner caring for the individual and the
103 transfer of prescription information between pharmacies;

104 (3) the transfer of prescription records that may occur when a
105 pharmacy's ownership is changed or transferred;

106 (4) care management educational communications provided to
107 an individual about the individual's health condition, adherence to
108 a prescribed course of therapy or other information relating to the
109 drug being dispensed, treatment options or clinical trials;

110 (5) transfers for the limited purpose of pharmacy reimburse-
111 ment, prescription drug formulary or prior authorization compli-

112 ance, patient care management, utilization review, health care
113 research or as required by law; and

114 (6) the collection, use, transfer or sale of prescription drug
115 information that is de-identified and that does not directly or indi-
116 rectly identify the individual or prescriber.

117 (d) A violation of this section shall be an unfair or deceptive
118 act or practice in the conduct of trade in violation of section 2 of
119 chapter 93A. Any person whose rights under this section have
120 been violated or attempted to be violated may institute and prose-
121 cute in his own name and on his own behalf, or the attorney
122 general, acting on behalf of the commonwealth, may institute a
123 civil action for injunctive and other equitable relief.

1 SECTION 4. The General Laws are hereby amended by
2 inserting after section 111K the following chapter:—

3 **CHAPTER 111L.**
4 **PRESCRIPTION DRUG MARKETING**
5 **RESTRICTIONS AND DISCLOSURE.**

6 Section 1. As used in this chapter, unless the context otherwise
7 indicates, the following terms shall have the following mean-
8 ings:—

9 “Bona fide clinical trial”, any research project that prospec-
10 tively assigns human subjects to intervention and comparison
11 groups to study the cause and effect relationship between a med-
12 ical intervention and a health outcome.

13 “Health care practitioner” or “practitioner”, a person who pre-
14 scribes prescription drugs for any person and licensed to provide
15 or is otherwise lawfully providing health care or a partnership or
16 corporation made up of those persons or an officer, employee,
17 agent or contractor of that person acting in the course and scope
18 of employment, agency or contract related to or supportive of the
19 provision of health care to individuals.

20 “Gift”, a payment, food, entertainment, travel, honorarium,
21 subscription, advance, services or anything of value, unless con-
22 sideration of equal or greater value is received. A gift includes
23 anything of value provided to a health care practitioner for less

24 than market value. “Gift” shall not include anything of value
25 received by inheritance, a gift received from a member of the
26 health care practitioner's immediate family or from a relative
27 within the third degree of consanguinity of the health care practi-
28 tioner or of the practitioner’s spouse or from the spouse of any
29 such relative, or prescription drugs provided to a health care prac-
30 titioner solely and exclusively for use by the practitioner's
31 patients.

32 “Immediate family”, a spouse and any dependent children
33 residing in the reporting person’s household.

34 “Labeler”, a person or entity that (a) receives prescription drugs
35 or biological products from a manufacturer or wholesaler;
36 (b) repackages the drugs or biological products for later resale;
37 and (c) has a labeler code from the federal Food and Drug Admin-
38 istration under section 207.20 of Title 21 of the Code of Federal
39 Regulations.

40 “Marketing”, advertising and promotional activities, including,
41 but not limited to, the activities described in section 2.

42 “Medical device”, an instrument, apparatus, implement,
43 machine, contrivance, implant, in vitro reagent, or other similar or
44 related article, including any component, part, or accessory, which
45 is:

46 (1) recognized in the official National Formulary, or the United
47 States Pharmacopeia, or any supplement to them;

48 (2) intended for use in the diagnosis of disease or other condi-
49 tions, or in the cure, mitigation, treatment, or prevention of dis-
50 ease, in man or other animals; or

51 (3) intended to affect the structure or any function of the body
52 of man or other animals, and which does not achieve its primary
53 intended purposes through chemical action within or on the body
54 of man or other animals and which is not dependent upon being
55 metabolized for the achievement of its primary intended purposes.

56 “Person”, a business, individual, corporation, union, associa-
57 tion, firm, partnership, committee, or other organization or group
58 of persons.

59 “Pharmaceutical marketer”, a person who, while employed by
60 or under contract to represent a pharmaceutical manufacturing
61 company, engages in pharmaceutical detailing, promotional activi-

62 ties, or other marketing of prescription drugs in this state to any
63 physician, hospital, nursing home, pharmacist, health benefit plan
64 administrator, or any other person authorized to prescribe, dis-
65 pense, or purchase prescription drugs. The term does not include
66 a wholesale drug distributor licensed under section 36A of
67 chapter 112, a representative of such a distributor who promotes
68 or otherwise markets the services of the wholesale drug distributor
69 in connection with a prescription drug, or a retail pharmacist reg-
70 istered under section 37 of chapter 112 if such person is not
71 engaging in such practices under contract with a manufacturing
72 company.

73 “Pharmaceutical manufacturing company”, any entity which is
74 engaged in the production, preparation, propagation, com-
75 pounding, conversion, or processing of prescription drugs, either
76 directly or indirectly by extraction from substances of natural
77 origin, or independently by means of chemical synthesis, or by a
78 combination of extraction and chemical synthesis, or any entity
79 engaged in the packaging, repackaging, labeling, relabeling, or
80 distribution of prescription drugs. The term does not include a
81 wholesale drug distributor licensed under section 36A of
82 chapter 112 or a retail pharmacist registered under section 37 of
83 chapter 112 or a medical device manufacturer that distributes
84 drugs as an incidental part of its device business.

85 “Pharmaceutical manufacturer agent”, a pharmaceutical mar-
86 keter or any other person who for compensation or reward does
87 any act to promote, oppose or influence the prescribing of a par-
88 ticular prescription drug or medical device or category of pre-
89 scription drugs or medical devices. The term shall not include a
90 licensed pharmacist, licensed physician or any other licensed
91 health care professional with authority to prescribe prescription
92 drugs who is acting within the ordinary scope of the practice for
93 which he is licensed.

94 “Prescription drugs”, any and all drugs upon which the manu-
95 facturer or distributor has placed or must, in compliance with fed-
96 eral law and regulations, place the following or a comparable
97 warning: “Caution federal law prohibits dispensing without pre-
98 scription.”

99 “Significant educational, scientific or policy-making confer-
100 ence or seminar”, an educational, scientific or policy-making con-

101 ference or seminar that offers continuing medical education credit,
102 features multiple presenters on scientific research, or is authorized
103 by the sponsoring association to recommend or make policy.

104 Section 2. No pharmaceutical manufacturer agent shall know-
105 ingly and willfully offer or give to a health care practitioner or a
106 member of a health care practitioner's immediate family or a
107 health care facility or employee or agent of a health care facility a
108 gift of any value. No health care practitioner or a member of a
109 health care practitioner's immediate family or health care facility
110 or employee or agent of a health care facility shall knowingly and
111 willfully solicit or accept from any pharmaceutical manufacturer,
112 a gift of any value. The restrictions in this paragraph do not
113 include the following items which would otherwise be considered
114 "gifts":

115 (1) payment to the sponsor of a significant educational, scien-
116 tific or policy-making conference or seminar medical conference,
117 provided the payment is not made directly to a health care practi-
118 tioner and is used solely for bona fide educational purposes and
119 that the amount and use of the funds is posted on a publicly avail-
120 able internet site;

121 (2) reasonable honoraria and payment of the reasonable
122 expenses of a health care practitioner who serves on the faculty at
123 a bona fide significant educational, scientific or policy-making
124 conference or seminar medical conference, provided that hono-
125 raria for speaking take place with an explicit contract with spe-
126 cific deliverables which are restricted to scientific issues, not
127 marketing efforts;

128 (3) compensation for the substantial professional or consulting
129 services of a practitioner in connection with a bona fide clinical
130 trial, provided that the consulting is done under an explicit con-
131 tract with specific deliverables which are restricted to scientific
132 issues, not marketing efforts;

133 (4) publications and educational materials.

134 Section 3. (a) A manufacturer or labeler of prescription drugs
135 dispensed in the commonwealth that employs, directs or utilizes
136 marketing representatives in the commonwealth shall report mar-
137 keting costs for prescription drugs in the commonwealth as pro-
138 vided in this section.

139 (b) By July 1st each year a manufacturer or labeler of prescrip-
140 tion drugs that directly or indirectly distributes prescription drugs
141 for dispensation to residents of the commonwealth shall file a
142 report with the department of public health, in the form and
143 manner provided by the department. The report must be accom-
144 panied by payment of a fee, as set by the department.

145 (c) The annual report filed under subsection (b) must include
146 the following information as it pertains to marketing activities
147 conducted within the commonwealth in a form that provides the
148 value, nature, purpose and recipient of the expense:

149 (1) All expenses associated with advertising, marketing and
150 direct promotion of prescription drugs through radio, television,
151 magazines, newspapers, direct mail and telephone communica-
152 tions as they pertain to residents of the commonwealth, including
153 a reasonable estimate of the value of expenses associated with
154 advertising purchased for a regional or national market that
155 includes advertising within the commonwealth. The expenses
156 shall include, but not be limited to, direct and indirect payments in
157 support of independent or continuing medical education programs,
158 including payments to medical education companies; design,
159 printing and production costs of patient education materials and
160 disease management materials distributed within the common-
161 wealth; consulting fees and expenses, participation in speakers'
162 bureaus and honoraria or other payments for time while speaking
163 at or attending meetings, lectures or conferences; writing articles
164 or publications; charitable grants, either directly or earmarked,
165 even if unrestricted; market research surveys or other activities
166 undertaken in support of developing advertising and/or marketing
167 strategies.

168 (2) With regard to all persons and entities licensed to provide
169 health care, including health care practitioners and persons
170 employed by them, carriers licensed under chapters 175, 176A,
171 176B, 176G, and 176I, health plans and benefits managers, phar-
172 macies, hospitals, nursing facilities, clinics and other entities
173 licensed to provide health care under this chapter, the following
174 information:

175 (i) All expenses associated with educational or informational
176 programs, materials and seminars and remuneration for promoting

177 or participating in educational or informational sessions, regard-
178 less of whether the manufacturer or labeler provides the educa-
179 tional or informational sessions or materials;

180 (ii) All expenses for gifts not otherwise prohibited in section 2,
181 and anything provided to a health care professional for less than
182 market value. The report must identify recipients by their state
183 board numbers or DEA numbers.

184 (iii) All expenses associated with product samples; and

185 (iv) The aggregate cost of all employees or contractors of the
186 manufacturer or labeler who directly or indirectly engage in the
187 advertising or promotional activities listed in paragraphs (1) and
188 (2) including all forms of payment to those employees. The cost
189 reported under this paragraph must reflect only that portion of
190 payment to employees or contractors that pertains to activities
191 within the commonwealth or to recipients of the advertising or
192 promotional activities who are residents of or are employed in the
193 commonwealth.

194 (d) The following marketing expenses are not subject to the
195 requirements of this section:

196 (1) expenses of \$25 or less;

197 (2) reasonable compensation and reimbursement for expenses
198 in connection with a bona fide clinical trial of a vaccine, therapy
199 or treatment; and

200 (3) scholarships and reimbursement of expenses for attending a
201 significant bona fide educational, scientific or policy-making con-
202 ference or seminar of a national, regional or specialty medical or
203 other professional association if the recipient of the scholarship is
204 chosen by the association sponsoring the conference or seminar.

205 Section 4. By January 1, 2009 and every 2 years after that date,
206 the department of public health shall file a report with the clerks
207 of the senate and house of representatives and the attorney
208 general, containing an analysis of the data submitted to the depart-
209 ment, including the scope of prescription drug marketing activities
210 and expenses and their effect on the cost, utilization and delivery
211 of health care services and any recommendations with regard to
212 marketing activities of prescription drug manufacturers and
213 labelers.

214 Section 5. Information submitted to the department pursuant to
215 this section is a public record except to the extent that it includes

216 information that is protected by state or federal law as a trade
217 secret. Data compiled by the department for the purposes of
218 reporting required by this section is a public record, as long as it
219 does not reveal information that is protected by state or federal
220 law as a trade secret. Notwithstanding any other provision of law,
221 the identity of health care practitioners and other recipients of
222 gifts, payments and materials required to be reported in this
223 chapter shall not constitute confidential information or trade
224 secrets protected under this section.

225 Section 6. This section may be enforced in a civil action
226 brought by the Attorney General. A person who violates this
227 section shall be punished by a fine of not more than \$5,000 or by
228 imprisonment for not more than 2 years, or both.

1 SECTION 5. Chapter 118E of the General Laws is hereby
2 amended by inserting after section 17 the following section:—

3 Section 17A. (a) As used in this section, unless the context oth-
4 erwise indicates, the following term has the following meaning:

5 “Evidence-based”, based on criteria and guidelines that reflect
6 high-quality, cost-effective care. The methodology used to deter-
7 mine such guidelines shall meet recognized standards for system-
8 atic evaluation of all available research and shall be free from
9 conflicts of interest. Consideration of the best available scientific
10 evidence shall not preclude consideration of experimental or
11 investigational treatment or services under a clinical investigation
12 approved by an institutional review board.

13 (b) The executive office of health and human services shall
14 coordinate an evidence-based pharmaceutical purchasing and pre-
15 scribing program for state agencies administering state purchased
16 health care programs and entities participating in state subsidized
17 health care programs. The program shall ensure, to the extent
18 practicable, the adoption of uniform policies for prudent, cost-
19 effective pharmaceuticals purchasing; maximize efficiencies in
20 administration; improvements in the quality of care; and reduction
21 in administrative burdens on health care providers participating in
22 state purchased health care programs. The policies adopted should
23 be based, to the extent possible, upon the best available scientific
24 and medical evidence.

25 (c) The executive office shall, by October 1, 2007, convene a
26 pharmaceutical quality and cost management task force, here-
27 inafter referred to as the task force. The task force shall coordinate
28 and exchange information among state agencies, stakeholder
29 groups, advisory committees, and provide advice to the executive
30 office and agencies thereof. The executive office and the office of
31 medicaid shall consult with the task force on at least a quarterly
32 basis on significant policy decisions related to implementation of
33 the purchasing and prescribing programs established in this
34 section. The executive office shall provide necessary staffing serv-
35 ices to the task force, which shall consist of the following mem-
36 bers appointed by the secretary:

37 (1) the secretary of health and human services, who shall serve
38 as chair;

39 (2) the Medicaid director or a designee;

40 (3) the commissioner of public health or a designee;

41 (4) the commissioner of mental health or a designee;

42 (5) the commissioner of mental retardation or a designee;

43 (6) the commissioner of corrections or a designee;

44 (7) a representative of private payors;

45 (8) a representative of the division of industrial accidents;

46 (9) a representative of the group insurance commission;

47 (10) a representative of the University of Massachusetts
48 Medical School;

49 (11) a member representing public education;

50 (12) a member representing municipalities or local govern-
51 ments;

52 (13) a clinical pharmacist;

53 (14) two licensed prescribers;

54 (15) a representative of the Masshealth drug utilization review
55 board;

56 (16) a representative of the Commonwealth Medicine division
57 of the University of Massachusetts Medical School;

58 (17) a representative of an organization representing racial and
59 ethnic minorities;

60 (18) a representatives of a health care consumer quality advo-
61 cacy group; and

62 (19) a representatives of a health care consumer legal advocacy
63 group.

64 (d) In consultation with the task force, the secretary shall
65 develop and implement an evidenced-based preferred drug list,
66 hereinafter referred to as PDL, to be used in the administration of
67 prescription drug benefits by MassHealth. Decisions regarding
68 drugs to be included in the PDL must be based on available, reli-
69 able evidence-based health information concerning pharmaceu-
70 tical efficacy, adverse effects and appropriate clinical trials, as
71 well as cost effectiveness. The PDL must also ensure that less
72 expensive generic drugs, other therapeutically equivalent alterna-
73 tives or other evidence-based treatment options will be substituted
74 for brand name drugs where the quality of care is not diminished,
75 and consider the approval of drugs with lower abuse potential in
76 substitution for drugs with significant abuse potential.

77 (e) In order to implement the purposes of this section, the office
78 of medicaid shall develop and implement a prior authorization
79 program to be administered in coordination with the PDL. The
80 program shall:

81 (1) identify clinically efficacious high-quality prescription
82 drugs that are also cost-effective; these drugs may not require
83 prior approval;

84 (2) be designed to ensure timely access to certain medically
85 necessary medications prescribed to medically fragile beneficia-
86 raries, including persons with mental illnesses, while allowing for
87 the exploration of appropriate options for reducing the costs of
88 pharmaceutical benefits and programs;

89 (3) minimize administrative burdens on health care practi-
90 tioners and patients and insure prompt turnaround on prior autho-
91 rization decisions;

92 (4) incorporate effective outreach to medical providers, phar-
93 macists and patients about how the program works;

94 (5) incorporate a transparent review process for the PDL and
95 prior authorization criteria while avoiding pharmaceutical industry
96 influence and conflicts of interest; and

97 (6) adopt rules allowing prescribers to be exempted from cer-
98 tain provisions of the prior authorization rules upon formal
99 endorsement of the PDL and associated procedures developed as
100 part of the program authorized by this section.

101 (f) To insure quality and efficiencies in the delivery of health
102 care services, while maximizing the use of evidence-based cri-

103 teria, the secretary shall to the extent practicable develop the PDL
104 to harmonize with preferred drug lists and formularies in use
105 throughout state agencies and in publicly funded, administered or
106 subsidized health programs including without limitation, programs
107 of the Commonwealth Health Insurance Connector Authority, the
108 group insurance commission, the departments of mental health,
109 mental retardation and corrections, and other agencies of the com-
110 monwealth.

111 (g) The executive office, in consultation with the task force,
112 shall directly or by contract, develop a joint pharmaceuticals pur-
113 chasing consortium. The consortium's purchasing activities shall
114 be based upon the evidence-based prescription drug program and
115 PDL established in this chapter.

116 (1) Participation in the purchasing consortium shall be offered
117 as an option on a voluntary basis to the Commonwealth Care
118 Health Insurance program and the departments of mental health,
119 mental retardation and corrections, and other agencies of the com-
120 monwealth no later than January 1, 2008. By July 1, 2008, the
121 secretary shall, in consultation with the task force, develop a plan
122 and an implementation timetable to require, to the extent practi-
123 cable and consistent with the purposes of this chapter, all state
124 purchasers and publicly funded, administered or subsidized health
125 programs to participate in the consortium by January 1, 2010. In
126 developing the consortium and the underlying harmonized PDL,
127 the department will seek to ensure, unless otherwise agreed to by
128 participating entities, that:

129 (i) participating plans are not fundamentally altered and that the
130 independent nature of any of the health plans involved in the con-
131 sortium is not compromised;

132 (ii) rebates are negotiated on behalf of the entire consortium,
133 and all participating plans share in the savings realized through
134 the pooled purchasing effort.

135 (2) Participation in the consortium shall be purely voluntary for
136 units of local government, private entities, labor organizations,
137 and for individuals who lack or are underinsured for prescription
138 drug coverage. The department may set reasonable fees, including
139 enrollment fees, to cover administrative costs attributable to par-
140 ticipation in the prescription drug consortium.

141 (3) If the department contracts on behalf of the consortium for
142 services with a pharmacy benefits manager or administrator or
143 other private entity for the negotiation of savings and rebates, it
144 shall insure full transparency of all financial terms and contracts
145 between the negotiating entity and the members of the consor-
146 tium; pass through of all financial benefits including rebates and
147 other discounts and payments without limitation; and a fiduciary
148 relationship between the negotiating entity and the consortium.

149 (4) There is hereby established an account within the executive
150 office of health human services known as the prescription drug
151 consortium account. All receipts from activities related to admin-
152 istration of the drug purchasing consortium on behalf of partici-
153 pating individuals and organizations, other than state purchased
154 health care programs, shall be deposited into the account. The
155 receipts shall include, but not be limited to, rebates from manufac-
156 turers, and the fees established pursuant to clause (2). Funds in
157 the account may be expended without further appropriation by the
158 secretary for the purposes of this section.

159 (h) The executive office is authorized to participate in joint pur-
160 chasing opportunities with other states that are consistent with the
161 evidence-based policies and other criteria established herein. If
162 the state participates in a multi-state purchasing pool that con-
163 tracts with a private entity for the negotiation of savings and
164 rebates, it shall insure full transparency of all financial terms and
165 contracts between the negotiating entity and the members of the
166 consortium; pass through of all financial benefits including
167 rebates and other discounts and payments without limitation; and
168 a fiduciary relationship between the negotiating entity and the
169 consortium.

170 (i) The department may implement other strategies to control
171 costs of drugs without reducing the quality of care consistent with
172 the evidence-based approach in this chapter, including but not
173 limited to authorizing reimbursement for drugs only in econom-
174 ical quantities and limiting the prices paid for drugs by such
175 means as negotiated discounts from pharmaceutical manufac-
176 turers, central purchasing, volume contracting, or setting max-
177 imum prices to be paid.

178 (j) The department shall enter into a contractual agreement with
179 the Oregon Health and Science University Drug Effectiveness

180 Review Project to provide technical and clinical support in the
181 development and the administration of the PDL and other evi-
182 dence-based programs established in this section.

183 (k) On March 1, 2008 and every year thereafter, the department
184 shall submit a report to the house and senate chairs of the joint
185 committee on health care financing and the chairs of the senate
186 and house committees on ways and means, on the progress in
187 meeting the timetable and goals of this section, as well as savings
188 achieved and any issues that need to be addressed.

189 Section 7. The department shall adopt regulations as necessary
190 to implement this section.

1 SECTION 6. The General Laws are hereby amended by
2 inserting after chapter 118H the following chapter:—

3 **CHAPTER 118I.**
4 **HEALTH CARE COST CONTROL.**

5 Section 1. As used in this chapter, the following words shall,
6 unless the context clearly requires otherwise, have the following
7 meanings:—

8 “Public payors”, agencies of the Commonwealth that purchase
9 or contract for health care and health care insurance services,
10 including, but not limited to, the Group Insurance Commission
11 established by section 3 of chapter 32A, the Commonwealth
12 Health Insurance Connector Authority, established by section 2 of
13 chapter 176Q, and the Medicaid and MassHealth programs estab-
14 lished by sections 9 and 9A of chapter 118E.

15 “Potentially preventable hospital readmission”, a patient’s read-
16 mission to a hospital within 30 days of a discharge from a hos-
17 pital, due to a condition that indicates the readmission was
18 potentially preventable during the initial hospital stay, as further
19 defined by regulations.

20 “Potentially preventable hospital complication”, a potentially
21 preventable harmful event or negative outcome that occurs to a
22 patient while in a hospital that results from the process of care and
23 treatment and not from any underlying disease, as further defined
24 by regulations.

25 Section 2. The executive office of health and human services
26 shall coordinate the creation of common, transparent quality and
27 payment metrics among public payors to facilitate administrative
28 savings and create standard, transparent methods for evaluating
29 health care prices and quality. The common quality and payment
30 metrics may include:

31 (1) a standard claims payment data set;

32 (2) standard units of payment, including cases, visits and pay-
33 ment methods; and

34 (3) a standard menu of performance measures, including
35 severity and risk adjustments.

36 Upon adoption of the common quality and payment metrics by
37 regulation, all public payors shall, to the extent possible, shall
38 implement the common quality and payment metrics.

39 Section 3. The executive office of health and human services
40 shall direct hospitals and insurers to provide data on potentially
41 preventable hospital readmissions. The secretary shall initially
42 consult with the health care quality and cost council established
43 by section 16K of chapter 6A, and its advisory committee,
44 regarding the data to be collected, and shall collect sufficient data
45 to determine for each hospital a rate of potentially preventable
46 hospital readmissions. The initial determinations for a hospital
47 shall be provided to the hospital for review, but shall not be public
48 information.

49 Following the review of its data by each hospital, the secretary
50 shall promulgate regulations directing hospitals and insurers to
51 provide data on potentially preventable hospital readmissions. No
52 more than one year following the initial determination of hospital
53 potentially preventable hospital readmission rates, the secretary
54 shall post on the consumer health information internet site the
55 potentially preventable hospital readmission data and rates for
56 each hospital. The rates shall be adjusted annually, or as the secre-
57 tary determines.

58 The secretary shall coordinate the creation of a common, trans-
59 parent payment methodology among public payors to reduce
60 potentially preventable hospital readmissions. The methodology
61 shall reduce or eliminate payment for potentially preventable hos-
62 pital readmissions. Upon adoption of the payment methodology
63 by regulation, all public payors shall, to the extent possible,
64 implement the common payment methodology.

65 Section 4. The executive office of health and human services
66 shall direct hospitals and insurers to provide data on potentially
67 preventable hospital complications. The secretary shall initially
68 consult with the health care quality and cost council established
69 by section 16K of chapter 6A, and its advisory committee,
70 regarding the data to be collected, and shall collect sufficient data
71 to determine for each hospital a rate of potentially preventable
72 hospital complications. The initial determinations for a hospital
73 shall be provided to the hospital for review, but shall not be public
74 information.

75 Following the review of its data by each hospital, the secretary
76 shall promulgate regulations directing hospitals and insurers to
77 provide data on potentially preventable hospital complications. No
78 more than one year following the initial determination of hospital
79 potentially preventable hospital complication rates, the secretary
80 shall post on the consumer health information internet site the
81 potentially preventable hospital complication data and rates for
82 each hospital. The rates shall be adjusted annually, or as the secre-
83 tary determines.

84 The secretary shall coordinate the creation of a common, trans-
85 parent payment methodology among public payors to reduce
86 potentially preventable hospital complications. The methodology
87 shall reduce or eliminate payment for potentially preventable hos-
88 pital complications. Upon adoption of the payment methodology
89 by regulation, all public payors shall, to the extent possible,
90 implement the common payment methodology.

91 Section 5. The executive office of health and human services
92 shall coordinate the creation of a common, transparent prospective
93 payment methodology among public payors for outpatient proce-
94 dures. The methodology shall provide a single prospective pay-
95 ment for all services provided in an outpatient visit in a hospital or
96 ambulatory surgery facility, and may include a single prospective
97 payment for a physician office visit. Upon adoption of the
98 prospective payment methodology by regulation, all public payors
99 shall, to the extent possible, implement the common prospective
100 payment methodology.

101 Section 6. The executive office of health and human services
102 shall coordinate the implementation of transparent evidence-based
103 episodes of care payment rates among public payors for patients

104 with chronic illnesses. Episodes of care payment rate methodolo-
105 gies shall encourage clinically integrated care based on evidence-
106 based guidelines that reflect high-quality, cost-effective care. The
107 methodology used to determine such guidelines shall meet recog-
108 nized standards for systematic evaluation of all available research
109 and shall be free from conflicts of interest. The methodology shall
110 include a comprehensive evaluation process that assesses clinical
111 quality and patient satisfaction. All details of the payment system
112 and care evaluation shall be transparent to patients and providers.
113 The rate methodologies shall provide an annual severity-adjusted
114 payment to a care coordination entity that will provide all clini-
115 cally appropriate care for the year. A portion of the payments shall
116 be contingent upon meeting clinical quality goals and patient sat-
117 isfaction standards. Upon adoption of the payment methodology
118 by regulation of the council, all public payors shall, to the extent
119 possible, implement the evidence-based episodes of care payment
120 rates for patients with chronic conditions.

1 SECTION 7. Chapter 175 of the General Laws is hereby
2 amended by inserting after section 47Z the following section:—

3 Section 47AA. (a) For purposes of this section, health insur-
4 ance plan shall include a policy or policies of group life and acci-
5 dental death and dismemberment insurance covering persons in
6 the service of the commonwealth, and group general or blanket
7 insurance providing hospital, surgical, medical, dental, and other
8 health insurance benefits covering persons in the service of the
9 commonwealth, and their dependents organized under
10 chapter 32A, individual or group health insurance policies offered
11 by an insurer licensed or otherwise authorized to transact accident
12 or health insurance organized under chapter 175, a nonprofit hos-
13 pital service corporation organized under chapter 176A, a non-
14 profit medical service corporation organized under chapter 176B,
15 a health maintenance organization organized under chapter 176G,
16 or an organization entering into a preferred provider arrangement
17 under chapter 176I, any health plan issued, renewed, or delivered
18 within or without the commonwealth to a natural person who is a
19 resident of the commonwealth, including a certificate issued to an
20 eligible natural person which evidences coverage under a policy
21 or contract issued to a trust or association for said natural person

22 and his dependent, including said person's spouse organized under
23 chapter 176M, and medical assistance and medical benefits under
24 the Medicaid and MassHealth programs established by sections 9
25 and 9A of chapter 118E, and coverage provided by the Common-
26 wealth Care Health Insurance Program under chapter 118H.

27 For purposes of this section, preventive care shall include any
28 periodic, routine, screening or other services designed for the pre-
29 vention and early detection of illness. This includes, but is not
30 limited to, immunizations; periodic health exams for adults and
31 children, as well as those mammograms, cytological exams and
32 diagnostic tests associated with periodic health exams; prenatal
33 maternity care; well child care, including vision and auditory
34 screening; voluntary family planning; nutrition counseling; and
35 health education. Preventive health care shall also include sup-
36 plies, equipment, medication and specialist provided treatments
37 and services for persons with chronic illnesses or disabling condi-
38 tions.

39 For purposes of this section, copayments or coinsurance
40 includes a fixed dollar or proportional amount that a person pays
41 under a health insurance plan in connection with the provision of
42 medical services, as further defined by regulations of the division.

43 (b) No health insurance plan shall charge copayments or coin-
44 surance for preventive health care.

1 SECTION 8. Subsection (a) of section 3 of chapter 176J of the
2 General Laws, as most recently amended by section 82 of
3 chapter 58 of the acts of 2006, is hereby further amended by
4 inserting after clause (6) the following clause:—

5 (7) Every carrier desiring to increase premiums or desiring to
6 set the initial premium shall file a rate filing or application with
7 the commissioner at least 90 days before the proposed effective
8 date of such new rates. The commissioner may disapprove the
9 proposed rates if the benefits provided are unreasonable in rela-
10 tion to the rate charged, or if they are excessive, inadequate or
11 unfairly discriminatory or do not otherwise comply with the
12 requirements of this chapter.

13 If a carrier files for an increase in premium of more than 7 per-
14 cent than the premium previously charged, or if a carrier files an
15 initial premium request that is more than 7 percent greater than

16 the average premium for the similar policies offered by carriers in
17 the same market, the carrier's rate, in addition to being subject to
18 all other provisions of this chapter and other provisions of law,
19 shall be subject to prior approval of the commissioner. In
20 granting such prior approval, the commissioner shall make a
21 finding on the basis of information submitted by the carrier and
22 investigated by the division and shall be subject to a public
23 hearing pursuant to this clause. The hearing shall comply with the
24 requirements of chapter 30A. The commissioner may consolidate
25 hearings for more than one carrier. The carrier shall provide infor-
26 mation on the reasons for the proposed increase in rates, and
27 members of the public may testify. All testimony and evidence
28 received shall be public records. The provisions of section 8A of
29 chapter 175 authorized the commissioner by summons to require
30 the attendance and testimony of witnesses under oath and the
31 production of books, records and papers touching upon the mat-
32 ters in question at such hearing shall apply to hearings under this
33 clause.

1 SECTION 9. The executive office of health and human services
2 shall convene a long-term care payment coordination task force to
3 develop a common comprehensive and transparent long-term care
4 payment methodology that rewards efficient, clinically proper
5 care in the most appropriate setting, without undue incentives to
6 choose a particular setting, that provides high value and best
7 meets patient and family needs. The task force shall consist of all
8 agencies of the commonwealth concerned with long-term care
9 policy, including the office of medicaid, the executive office of
10 elder affairs, the division of health care finance and policy, and
11 the department of public health. The task force shall consult with
12 experts in the field of long-term care, long-term care providers,
13 consumer health organizations, and organizations representing the
14 elderly, the disabled and racial and ethnic minority groups. The
15 task force shall invite participation by the Centers for Medicare
16 and Medicaid Services.

17 The secretary shall file a report detailing the findings, recom-
18 mendations and implementation plan of the task force, along with
19 any legislation needed to implement its recommendations, with
20 the committee on health care financing and the committees on

21 ways and means no later than 6 months after the effective date of
22 this act.

1 SECTION 10. The executive office of health and human serv-
2 ices shall maximize enrollment of eligible persons in the
3 MassHealth Senior Care Options program and shall develop a
4 plan to offer similar coverage to Medicaid and Medicare-eligible
5 disabled persons under age 65, hereinafter referred as dual eligible
6 plans.

7 No later than 6 months after the effective date of this act, the
8 executive office of health and human services shall prepare a
9 report identifying clinical, administrative and financial barriers to
10 expanded dual eligible plans, and recommended steps to remove
11 the barriers and implement coverage for Medicaid and Medicare-
12 eligible disabled persons under age 65. Before finalizing the
13 report, the executive office shall hold a public consultative session
14 that includes organizations representing seniors, organizations
15 representing disabled persons, organizations representing health
16 care consumers, organizations representing racial and ethnic
17 minorities, health delivery systems, and health care providers. The
18 report shall consider changes in procurement standards and
19 MassHealth payment methodologies to promote enrollment in
20 dual eligible plans. The report shall estimate the costs and benefits
21 of implementing steps to remove barriers to expanded enrollment
22 in dual eligible plans, including financial savings and improved
23 quality of care.

24 The report shall be provided to the committee on health care
25 financing, the house and senate committees on ways and means,
26 and shall be posted on the internet site of the executive office of
27 health and human services.

28 Subject to appropriation, the executive office of health and
29 human services shall implement the steps recommended by the
30 report. No later than one year following the filing of the report,
31 the executive office shall issue a progress statement on expanded
32 enrollment in dual eligible plans.

1 SECTION 11. The executive office of health and human
2 services and the Commonwealth Health Insurance Connector
3 Authority shall prepare and implement a plan to make MassHealth

4 and Commonwealth Care leaders in the use of advanced health
5 information technology and electronic health records. The plan
6 shall be developed in consultation with the Massachusetts
7 e-Health Collaborative, the Massachusetts Health Data Consor-
8 tium, MassPRO, consumer health organizations, consumer privacy
9 organizations, providers and others concerned about health infor-
10 mation technology and electronic health records.

11 The secretary shall file a report detailing the findings, recom-
12 mendations and implementation plan, along with any legislation
13 needed to implement its recommendations, with the committee on
14 health care financing and the committees on ways and means no
15 later than 6 months after the effective date of this act.

1 SECTION 12. There is hereby established a special commis-
2 sion to strengthen primary care. The commission shall consist of
3 the secretary of health and human services, who shall serve as
4 chair, 2 senators appointed by the president of the senate, 2 mem-
5 bers of the house of representatives appointed by the speaker, the
6 commissioner of public health, a representative of the Massachu-
7 setts Academy of Family Physicians, a representative of the
8 Massachusetts Medical Society, a representative of the Massachu-
9 setts chapter of the American College of Physicians, a representa-
10 tive of the Massachusetts Nurses Association, a representative of
11 the Massachusetts Association of Nurse Practitioners, a represen-
12 tative of the Massachusetts League of Community Health Centers,
13 a representative of University of Massachusetts Medical School, a
14 representative of the Massachusetts Public Health Association, a
15 representative of the Massachusetts Association of Physician
16 Assistants and a representative of Health Care For All.

17 The commission shall conduct a study and make recommenda-
18 tions for executive and legislative action to strengthen primary
19 care in the commonwealth. The study shall review the availability
20 of primary care services, identify regions of the state with
21 impaired access to primary care, examine the impact of lack of
22 access to primary care on the health status of the commonwealth,
23 including racial, ethnic, gender, income and other disparities in
24 health due to the lack of access to primary care, estimate the addi-
25 tional costs to the health care system due to the lack of availability
26 of primary care, recommend methods to recruit and increase the

27 availability of primary care practitioners, recommend changes in
28 licensing, reimbursement rates and methodologies to strengthen
29 primary care, and make such other findings and recommendations
30 as the commission shall determine.

31 The commission shall hold at least three public hearings in dif-
32 ferent regions to receive testimony from the public on primary
33 care concerns.

34 The commission shall report its findings to the clerks of the
35 house and senate no later than December 31, 2007. The commis-
36 sion's report shall be posted on the internet site of the executive
37 office of health and human services.