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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2021

A N A C T

RELATING TO INSURANCE

Introduced By: Senators Ruggerio, McCaffrey, Goodwin, Miller, and Coyne

Date Introduced: March 04, 2021

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Title 27 of the General Laws entitled “INSURANCE” is hereby amended by adding thereto the following chapter:

CHAPTER 82

THE DRUG COST TRANSPARENCY ACT

27-82-1. Definitions.

As used in this chapter:

(1) "Health plan" or "health benefit plan" means health insurance coverage and a group health plan, including coverage provided through an association plan if it covers Rhode Island residents. Except to the extent specifically provided by the federal Affordable Care Act, the term "health plan" shall not include a group health plan to the extent state regulation of the health plan is preempted under section 514 [29 U.S.C. § 1144] of the federal Employee Retirement Income Security Act of 1974. The term also shall not include:

(i) Coverage only for accident, or disability income insurance, or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, the federal health insurance portability and accountability act of 1996 ("HIPAA"), under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) "Health benefit plan issuer" means a health insurance company, health insurance carrier, a health maintenance organization, or a hospital and medical service corporation.

(3) "Office of the health insurance commissioner" or "office" means the office created pursuant to § 42-14.5-1.

(4) "Prescription drug" and "drug" means a drug as defined in 21 U.S.C. § 321, except that the term prescription drug or drug does not include a device or an animal health product.

(5) "Pharmacy benefit manager" means an entity doing business in this state that contracts to administer or manage prescription-drug benefits on behalf of any carrier that provides prescription-drug benefits to residents of this state.

(6) "Pharmaceutical drug manufacturer" means a person engaged in the business of producing, preparing, propagating, compounding, converting, processing, packaging, repackaging, labeling, or distributing a drug. The term "pharmaceutical drug manufacturer" does not include a wholesale distributor or retailer of prescription drugs or a pharmacist licensed under chapter 19.1 of title 5.

(7) "Rebate" means a discount or concession that affects the price of a prescription drug to a pharmacy benefit manager or health benefit plan issuer for a prescription drug manufactured by the pharmaceutical drug manufacturer.

(8) "Specialty drug" means a prescription drug covered under Medicare Part D that exceeds the specialty tier cost threshold established by the Centers for Medicare and Medicaid Services.

(9) "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.

(10) "Wholesale acquisition cost" means, with respect to a drug, the pharmaceutical drug manufacturer's list price for the drug charged to wholesalers or direct purchasers in the United States, as reported in wholesale price guides or other publications of drug pricing data. The cost does not include any rebates, prompt pay or other discounts, or other reductions in price.

27-82-2. Disclosure of pharmaceutical drug manufacturer information.

(a)(1) On or before February 1, 2022 and every February 1 of each year thereafter, each pharmaceutical drug manufacturer shall submit a report to the office of the health insurance

commissioner stating the current wholesale acquisition cost information for the United States Food and Drug Administration approved drugs sold in or offered for sale in this state by that manufacturer.

(2) The office shall develop a website to provide to the general public drug price information submitted under subsection (a)(1) of this section. The website shall be made available on the office's website with a dedicated link that is prominently displayed on the home page or by a separate easily identifiable Internet address.

(b)(1) This subsection applies only to a drug with a wholesale acquisition cost of at least one hundred dollars ($100) for a thirty (30) day supply before the effective date of an increase described by this subsection. Not later than the thirtieth day after the effective date of an increase of forty percent (40%) or more over the preceding three (3) calendar years or fifteen percent (15%) or more in the preceding calendar year in the wholesale acquisition cost of a drug to which this subsection applies, a pharmaceutical drug manufacturer shall submit a report to the office. The report must include the following information:

(i) The name of the drug;

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

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

(iv) Aggregate, company-level research and development costs for the most recent year for which final audit data is available;

(v) The name of each of the manufacturer's prescription drugs approved by the United States Food and Drug Administration in the previous three (3) calendar years;

(vi) The name of each of the manufacturer's prescription drugs that lost patent exclusivity in the United States in the previous three (3) calendar years; and

(vii) A statement regarding the factor or factors that caused the increase in the wholesale acquisition cost and an explanation of the role of each factor's impact on the cost.

(2) The quality and types of information and data that a pharmaceutical drug manufacturer submits to the office under subsection (b)(1) of this section must be consistent with the quality and types of information and data that the manufacturer includes in the manufacturer's annual consolidated report on Securities and Exchange Commission Form 10-K or any other public disclosure.

(c) Not later than the sixtieth day after receipt of the report submitted under subsection (a) of this section, the office of the health insurance commissioner shall publish the report on the office's website described by subsection (a)(2) of this section.

(d) 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 a wholesale acquisition cost of at least one hundred dollars ($100) for a thirty (30) day supply. The manufacturer shall provide the written notice within three (3) calendar days following the release of the drug in the commercial market. A manufacturer may make the notification pending approval by the United States Food and Drug Administration (FDA) if commercial availability is expected within three (3) calendar days following the approval.

(e) The office of the health insurance commissioner shall promulgate any and all rules and regulations deemed necessary for the implementation of this section.

27-82-3. Disclosure of pharmacy benefit management information.

(a) On or before February 1, 2022 and every February 1 of each year thereafter, each pharmacy benefit manager shall file a report with the office of the health insurance commissioner. The report must state for the immediately preceding calendar year:

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

(2) The aggregated dollar amount of rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers that were:

(i) Passed to:

(A) A health benefit plan issuer; or

(B) Enrollees at the point of sale of a prescription drug; or

(ii) Retained as revenue by the pharmacy benefit manager.

(b) Notwithstanding subsection (a) of this section, the report due after February 1, 2022, under that subsection must state the required information for the immediately preceding three (3) calendar years in addition to stating the required information for the preceding calendar year. Subsection (b) of this section shall not apply to any report required after February 1, 2022.

(c) A report submitted by a pharmacy benefit manager may not disclose the identity of a specific health benefit plan or enrollee, the price charged for a specific prescription drug or class of prescription drugs, or the amount of any rebate or fee provided for a specific prescription drug or class of prescription drugs.

(d) Not later than the sixtieth day after receipt of the report submitted under subsection (a) of this section, the office of the health insurance commissioner shall publish the report on the office's website developed under § 27-82-2(a)(2).

(e) The office of the health insurance commissioner shall promulgate any and all rules and regulations deemed necessary for the implementation of this section.

27-82-4. Disclosure of health benefit plan issuer information.

(a) On or before February 1, 2022 and every February 1 of each year thereafter, each health benefit plan issuer shall submit to the office of the health insurance commissioner a report that states for the immediately preceding calendar year:

(1) The names of the twenty-five (25) most frequently prescribed prescription drugs across all plans;

(2) The names of the ten (10) highest-cost hospital procedures across all plans regulated by the state;

(3) The names of the hospitals with the highest payment rates for the procedures listed in subsection (a)(2) of this section;

(4) The percent increase in annual net spending for prescription drugs and annual spend for hospital services compared to other components of the health care premium across all plans;

(5) The percent increase in premiums that were attributable to prescription drugs and to hospitals compared to other components of the health care premium across all plans;

(6) The percentage of specialty drugs, and hospital procedures listed in subsection (a)(2) of this section, with utilization management requirements across all plans; and

(7) The premium reductions that were attributable to specialty drug utilization management.

(b) If the health benefit plan issuer is nonprofit or tax-exempt, the report required under subsection (a) of this section shall contain the following information for the preceding calendar year:

(1) Premium reductions due to tax-exempt status;

(2) Percentage of plans provided free or below cost to the general public;

(3) List and explain the impact of social welfare programs on improving health and lowering health care costs;

(4) Amount of reserves in dollars; and

(5) Amount of reserves as a percentage of the minimum required by the state of Rhode Island.

(c) Not later than the sixtieth day after receipt of the report submitted under subsection (a) of this section, the office of the health insurance commissioner shall publish the report on the office's website developed under § 27-82-2(a)(2).

(d) A report submitted by a health benefit plan issuer may not disclose the identity of a specific health benefit plan or the price charged for a specific prescription drug or class of prescription drugs.

(e) The office of the health insurance commissioner shall promulgate any and all rules and

regulations deemed necessary for the implementation of this section.

27-82-5. Disclosure of hospital pricing information.

(a) Not later than February 1, 2022, and annually thereafter, each hospital identified in § 27-82-4(a)(3) shall submit a report to the office. The report shall contain the following information for the immediately preceding calendar year:

(1) All factors used to establish and justify the chargemaster price for the procedure;

(2) The percentage of the chargemaster price attributable to each factor;

(3) An explanation of the role of each factor in establishing the chargemaster price;

(4) The number and percentage of patients for whom adverse information was reported to consumer credit reporting agencies or credit bureaus; and

(5) The number of patients against whom the hospital filed medical debt lawsuits or took other legal action.

(b) If the hospital is nonprofit or tax-exempt, the report required under subsection (a) shall contain the following information for the most recent calendar year with auditable data:

(1) The number of patients for whom the hospital limited the amount charged to the patient for an emergency or other medically necessary care pursuant to section 501(r)(5) of the federal Internal Revenue Code;

(2) The average dollar amount by which charges were limited per patient by the hospital pursuant to 26 U.S.C. § 501(r)(5) of the federal Internal Revenue Code; and

(3) The number of patients the hospital determined were eligible for assistance under the hospital organization's financial assistance policy pursuant to 26 U.S.C. § 501(r)(4)(A) of the federal Internal Revenue Code before engaging in extraordinary collection actions against that individual pursuant to 26 U.S.C. § 501(r)(6) of the federal Internal Revenue Code.

(c) Not later than the sixtieth day after receipt of the report submitted under subsection (a) of this section, the office of the health insurance commissioner shall publish the report on the office's website developed under § 27-82-2(a)(2).

(d) The office of the health insurance commissioner shall promulgate any and all rules and regulations deemed necessary for the implementation of this section.

27-82-6. Severability.

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

SECTION 2. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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This act would require that pharmaceutical companies disclose to the office of the health insurance commissioner acquisition costs of drugs approved by the Federal Drug Administration, if the acquisition cost is at least one hundred dollars ($100) for a thirty (30) day supply. This also requires the disclosure of pharmacy benefit management information to include rebates, price protection payments and other payments that are saved by the pharmacy, health plan issuer or enrollees at the point of sale of the drug.

This act would take effect upon passage.

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