

Sen. Cavanaugh, Dist 16
Sen. Feltes, Dist 15
Sen. Fuller Clark, Dist 21
Sen. Rosenwald, Dist 13
Sen. Sherman, Dist 24
June 2, 2020
2020-1298s
01/10

Amendment to HB 1280-FN

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

2

3 AN ACT relative to copayments for insulin, establishing a wholesale prescription drug
4 importation program, establishing the New Hampshire prescription drug competitive
5 marketplace, relative to prescription drug benefits paid by health plans, relative to
6 transparency in prescription drug pricing, establishing a New Hampshire
7 prescription drug affordability board, relative to the pricing of generic prescription
8 drugs, relative to prior authorization for prescription drug coverage, and requiring
9 insurance coverage for epinephrine auto-injectors.

10

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

12

13 1 Accident and Health Insurance; Coverage for Diabetes Services and Supplies; Individual.

14 Amend RSA 415:6-e to read as follows:

15 415:6-e Coverage for Diabetes Services and Supplies. Each insurer that issues or renews any
16 individual policy, plan, or contract of accident or health insurance providing benefits for medical or
17 hospital expenses, shall provide to certificate holders of such insurance, who are residents of this
18 state, coverage for medically appropriate and necessary outpatient self-management training and
19 educational services, pursuant to a written order of a primary care physician or practitioner,
20 including but not limited to medical nutrition therapy for the treatment of diabetes, provided by a
21 certified, registered, or licensed health care professional with expertise in diabetes, subject to the
22 terms and conditions of the policy. Each insurer that issues or renews any individual policy, plan, or
23 contract of accident or health insurance providing benefits for medical or hospital expenses which
24 provides a prescription rider shall cover medically appropriate or necessary insulin, oral agents, and
25 equipment used to treat diabetes subject to the terms and conditions of the policy. ***An insurer that
26 provides coverage for prescription insulin drugs shall cap the total amount that a covered
27 person is required to pay for covered prescription insulin drugs at an amount not to exceed
28 \$100 for a 30-day supply of insulin drugs, regardless of the amount, type, or number of
29 insulins needed. Coverage for prescription insulin drugs shall not be subject to any
30 deductible. Each insurer that issues or renews any individual policy, plan, or contract of accident
31 or health insurance providing benefits for medical or hospital expenses which provides for durable***

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1 medical equipment coverage shall provide coverage for medically appropriate or necessary
2 equipment used to treat diabetes subject to the terms and conditions of the policy.

3 2 Accident and Health Insurance; Coverage for Diabetes Services and Supplies; Group. Amend
4 RSA 415:18-f to read as follows:

5 415:18-f Coverage for Diabetes Services and Supplies. Each insurer that issues or renews any
6 policy, plan, or contract of group accident or health insurance providing benefits for medical or
7 hospital expenses, shall provide each group, or to the portion of each group comprised of certificate
8 holders of such insurance who are residents of this state, coverage for medically appropriate and
9 necessary outpatient self-management training and educational services, pursuant to a written
10 order of a primary care physician or practitioner, including but not limited to medical nutrition
11 therapy for the treatment of diabetes, provided by a certified, registered, or licensed health care
12 professional with expertise in diabetes, subject to the terms and conditions of the policy. Each
13 insurer that issues or renews any group policy, plan, or contract of accident or health insurance
14 providing benefits for medical or hospital expenses which provides a prescription rider shall cover
15 medically appropriate or necessary insulin, oral agents, and equipment used to treat diabetes subject
16 to the terms and conditions of the policy. ***An insurer that provides coverage for prescription***
17 ***insulin drugs shall cap the total amount that a covered person is required to pay for***
18 ***covered prescription insulin drugs at an amount not to exceed \$100 for a 30-day supply of***
19 ***insulin drugs, regardless of the amount, type, or number of insulins needed. Coverage for***
20 ***prescription insulin drugs shall not be subject to any deductible.*** Each insurer that issues or
21 renews any group policy, plan, or contract of accident or health insurance providing benefits for
22 medical or hospital expenses which provides for durable medical equipment coverage shall provide
23 coverage for medically appropriate or necessary equipment used to treat diabetes subject to the
24 terms and conditions of the policy.

25 3 Health Service Corporations; Coverage for Diabetes Services and Supplies. Amend RSA 420-
26 A:17-a to read as follows:

27 420-A:17-a Coverage for Diabetes Services and Supplies. Every health service corporation and
28 every similar corporation licensed under the laws of another state that issues or renews any policy,
29 plan, or contract of individual or group accident or health insurance providing benefits for medical or
30 hospital expenses, shall provide to each individual or group, or to the portion of each group
31 comprised of certificate holders of such insurance who are residents of this state, coverage for the
32 medically appropriate and necessary outpatient self-management training and educational services,
33 pursuant to a written order of a primary care physician or practitioner, including but not limited to
34 medical nutrition therapy for the treatment of diabetes, provided by a certified, registered, or
35 licensed health care professional with expertise in diabetes, subject to the terms and conditions of
36 the policy. Each health service corporation that issues or renews any individual or group policy,
37 plan, or contract of accident or health insurance providing benefits for medical or hospital expenses

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1 which provides a prescription rider shall cover medically appropriate or necessary insulin, oral
2 agents, and equipment used to treat diabetes subject to the terms and conditions of the policy. ***Each***
3 ***health service corporation that provides coverage for prescription insulin drugs shall cap***
4 ***the total amount that a covered person is required to pay for covered prescription insulin***
5 ***drugs at an amount not to exceed \$100 for a 30-day supply of insulin drugs, regardless of***
6 ***the amount, type, or number of insulins needed. Coverage for prescription insulin drugs***
7 ***shall not be subject to any deductible.*** Each health service corporation that issues or renews any
8 individual or group policy, plan, or contract of accident or health insurance providing benefits for
9 medical or hospital expenses which provides for durable medical equipment coverage shall provide
10 coverage for medically appropriate or necessary equipment used to treat diabetes subject to the
11 terms and conditions of the policy.

12 4 Health Maintenance Organizations; Coverage for Diabetes Services and Supplies. Amend
13 RSA 420-B:8-k to read as follows:

14 420-B:8-k Coverage for Diabetes Services and Supplies. Every health maintenance organization
15 and every similar corporation licensed under the laws of another state that issues or renews any
16 policy, plan, or contract of individual or group health insurance providing benefits for medical or
17 hospital expenses, shall provide to each individual or group, or to the portion of each group
18 comprised of certificate holders of such insurance who are residents of this state, coverage for the
19 medically appropriate and necessary outpatient self-management training and educational services,
20 pursuant to a written order of a primary care physician or practitioner, including but not limited to
21 medical nutrition therapy for the treatment of diabetes, provided by a certified, registered, or
22 licensed health care professional with expertise in diabetes, subject to the terms and conditions of
23 the policy. Each health maintenance organization that issues or renews any individual or group
24 policy, plan, or contract of accident or health insurance providing benefits for medical or hospital
25 expenses which provides a prescription rider shall cover medically appropriate or necessary insulin,
26 oral agents, and equipment used to treat diabetes subject to the terms and conditions of the policy.
27 ***Each health maintenance organization that provides coverage for prescription insulin***
28 ***drugs shall cap the total amount that a covered person is required to pay for covered***
29 ***prescription insulin drugs at an amount not to exceed \$100 for a 30-day supply of insulin***
30 ***drugs, regardless of the amount, type, or number of insulins needed. Coverage for***
31 ***prescription insulin drugs shall not be subject to any deductible.*** Each health maintenance
32 organization that issues or renews any individual or group policy, plan, or contract of accident or
33 health insurance providing benefits for medical or hospital expenses which provides for durable
34 medical equipment coverage shall provide coverage for medically appropriate or necessary
35 equipment used to treat diabetes subject to the terms and conditions of the policy.

36 5 New Chapter; Health Plans That Provide Prescription Drug Benefits. Amend RSA by
37 inserting after chapter 402-N the following new chapter:

CHAPTER 402-O

HEALTH PLANS THAT PROVIDE PRESCRIPTION DRUG BENEFITS

402-O:1 Definitions. In this chapter:

I. "Average wholesale price" means the average wholesale price of a prescription drug as identified by a national drug pricing source selected by a health insurer. The average wholesale price must be identified by the 11-digit national drug code, as amended from time to time, for the prescription drug dispensed for the quantity dispensed.

II. "Brand-name drug" means a prescription drug marketed under a proprietary name or registered trademark name, including a biological product.

III. "Commissioner" means the insurance commissioner.

IV. "Compensation" means any direct or indirect financial benefit, including, but not limited to, rebates, discounts, credits, fees, grants, charge-backs or other payments or benefits of any kind.

V. "Contracted pharmacy" means "contracted pharmacy" as defined in RSA 420-J:3, X-a.

VI. "Cost-sharing amount" means the amount paid by a covered person as required under the covered person's health plan for a prescription drug at the point of sale.

VII. "Covered person" means "covered person" as defined in RSA 420-J:3, XII.

VIII. "Dispensing fee" means the professional fee incurred at the point of sale or service that pays for pharmacy costs, in excess of ingredient cost, associated with ensuring that possession of the appropriate prescription drug is transferred to a covered person.

IX. "Formulary" means a list of prescription drugs covered by a health benefit plan and any tier levels applicable to a prescription drug.

X. "Generic drug" means a prescription drug, whether identified by its chemical, proprietary or nonproprietary name, that is not a brand-name drug and is therapeutically equivalent to a brand-name drug in dosage, safety, strength, method of consumption, quality, performance and intended use. "Generic drug" includes a biosimilar product.

XI. "Health carrier" means "health carrier" as defined in RSA 420-J:3, XXIII.

XII. "Health benefit plan" means "health benefit plan" as defined in RSA 420-J:3, XIX.

XIII. "Ingredient cost" means the actual amount paid to a pharmacy provider by a carrier or the carrier's pharmacy benefits manager for a prescription drug, not including the dispensing fee or cost-sharing amount.

XIV. "Mail order pharmacy" means "mail order pharmacy" as defined in RSA 318:1, VII-b.

XV. "Maximum allowable cost" means the maximum amount a health insurer will pay for a generic drug or brand-name drug that has at least one generic alternative available.

XVI. "Pharmacy" means "pharmacy" as defined in RSA 318:1, XI.

XVII. "Pharmacy and therapeutics committee" means a committee, board or equivalent body established by a health carrier to develop and maintain formularies.

XVIII. "Pharmacy benefits manager" means a person who performs pharmacy benefits management services, including a person acting on behalf of a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management services for a covered entity. "Pharmacy benefits manager" shall include a health insurer licensed in this state if the health insurer or its subsidiary is providing pharmacy benefits management services exclusively to its own insureds. "Pharmacy benefits manager" shall not include a private single employer self-funded plan that provides such benefits or services directly to its beneficiaries. "Pharmacy benefits management" means the administration of prescription drug benefits provided by a covered entity under the terms and conditions of the contract between the pharmacy benefits manager and the covered entity and the provision of mail order pharmacy services.

XIX. "Pharmacy provider" means a retail pharmacy, mail order pharmacy, or licensed pharmacist.

XX. "Retail pharmacy" means a chain pharmacy, a supermarket pharmacy, a mass merchandiser pharmacy, an independent pharmacy or a network of independent pharmacies that is licensed as a pharmacy by this state and that dispenses medications to the public.

402-O:2 Oversight and Contracting Responsibilities.

I. A health insurer shall ensure that oversight and management of its prescription drug benefits, whether managed and administered directly by the insurer, or by a pharmacy benefits manager under contract with the insurer, meets the requirements of this chapter.

II. A health carrier that contracts with a pharmacy benefits manager to perform any activities related to the health carrier's prescription drug benefits is responsible for ensuring that, under the contract, the pharmacy benefits manager acts as the health carrier's agent and owes a fiduciary duty to the health carrier in the pharmacy benefits manager's management of activities related to the health carrier's prescription drug benefits.

III. A health carrier shall not enter into a contract or agreement or allow a pharmacy benefits manager or any person acting on the health carrier's behalf to enter into a contract or agreement that prohibits a pharmacy provider from:

(a) Providing a covered person with the option of paying the pharmacy provider's cash price for the purchase of a prescription drug and not filing a claim with the covered person's health carrier if the cash price is less than the covered person's cost-sharing amount; or

(b) Providing information to a state or federal agency, law enforcement agency, or the commissioner when such information is required by law.

IV.(a) A health carrier or pharmacy benefits manager shall not require a covered person to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of:

(1) The applicable cost-sharing amount for the prescription drug.

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1 (2) The amount a covered person would pay for the prescription drug if the covered
2 person purchased the prescription drug without using a health plan or any other source of
3 prescription drug benefits or discounts.

4 (3) The total amount the pharmacy will be reimbursed for the prescription drug from
5 the pharmacy benefits manager or carrier, including the cost-sharing amount paid by a covered
6 person.

7 (4) The amount a health carrier or pharmacy benefits manager would pay for the
8 prescription drug if the carrier or pharmacy benefits manager paid the pharmacy the full amount for
9 the drug, with no cost sharing due.

10 (b) When calculating the cost-sharing for any prescription subject to a co-insurance, a
11 health carrier or pharmacy benefits manager shall use the amount the pharmacy will be reimbursed
12 for the prescription drug from the health carrier or pharmacy benefits manager minus any cost-
13 sharing to be paid by a covered person.

14 V. A health carrier shall provide a reasonably adequate retail pharmacy network for the
15 provision of prescription drugs for its covered persons. A mail order pharmacy shall not be included
16 in determining the adequacy of a retail pharmacy network.

17 402-O:3 Prescription Drug Pricing; Maximum Allowable Cost.

18 I. A health carrier, or a pharmacy benefits manager under contract with a health carrier,
19 shall use a single maximum allowable cost list to establish the maximum amount to be paid by a
20 health plan to a pharmacy provider for a generic drug or a brand-name drug that has at least one
21 generic alternative available. A health carrier, or a pharmacy benefits manager under contract with
22 a health carrier, shall use the same maximum allowable cost list for each pharmacy provider.

23 II. A maximum allowable cost may be set for a prescription drug, or a prescription drug may
24 be allowed to continue on a maximum allowable cost list, only if that prescription drug:

25 (a) Is rated as "A" or "B" in the most recent version of the United States Food and Drug
26 Administration's (FDA) "Approved Drug Products with Therapeutic Equivalence Evaluations," also
27 known as "the Orange Book," or an equivalent rating from a successor publication, or is rated as
28 "NR" or "NA" or a similar rating by a nationally recognized pricing reference; and

29 (b) Is not obsolete and is generally available for purchase in New Hampshire from a
30 national or regional wholesale distributor by pharmacies having a contract with the pharmacy
31 benefits manager.

32 III. A health carrier, or a pharmacy benefits manager under contract with a health carrier,
33 shall provide a reasonable administrative appeal procedure, including a right to appeal that is
34 limited to 14 days following the initial claim, to allow pharmacies with which the health carrier or
35 pharmacy benefits manager has a contract to challenge maximum allowable costs for a specified
36 drug.

1 IV. A health carrier, or a pharmacy benefits manager under contract with a health carrier,
2 shall respond to, investigate, and resolve an appeal under paragraph III within 14 days after the
3 receipt of the appeal. The health carrier or pharmacy benefits manager shall respond to an appeal
4 as follows:

5 (a) If the appeal is upheld, the health carrier or pharmacy benefits manager shall make
6 the appropriate adjustment in the maximum allowable cost and permit the challenging pharmacy or
7 pharmacist to reverse and rebill the claim in question; or

8 (b) If the appeal is denied, the health carrier or pharmacy benefits manager shall
9 provide the challenging pharmacy or pharmacist the national drug code from national or regional
10 wholesalers of a comparable prescription drug that may be purchased at or below the maximum
11 allowable cost.

12 V. A health carrier, or a pharmacy benefits manager under contract with a health carrier,
13 shall use the average wholesale price to establish the maximum payment for a brand-name drug for
14 which a generic equivalent is not available or a prescription drug not included on a maximum
15 allowable cost list. In order to use the average wholesale price of a brand-name drug or prescription
16 drug not included on a maximum allowable cost list, a health carrier, or a pharmacy benefits
17 manager under contract with a health carrier, shall use only one national drug pricing source during
18 a calendar year, except that a health carrier, or a pharmacy benefits manager under contract with a
19 health carrier, may use a different national drug pricing source if the original pricing source is no
20 longer available. A health carrier, or a pharmacy benefits manager under contract with a health
21 carrier, shall use the same national drug pricing source for each pharmacy provider and identify on
22 its publicly accessible website the name of the national drug pricing source used to determine the
23 average wholesale price of a prescription drug not included on the maximum allowable cost list.

24 VI. This paragraph governs payments between a health carrier or a health carrier's
25 pharmacy benefits manager and a pharmacy provider.

26 (a) The amount paid by a health carrier or a health carrier's pharmacy benefits manager
27 to a pharmacy provider under contract with the health carrier or the health carrier's pharmacy
28 benefits manager for dispensing a prescription drug shall be the ingredient cost plus the dispensing
29 fee less any cost-sharing amount paid by a covered person.

30 (b) The ingredient cost may not exceed the maximum allowable cost or average
31 wholesale price, as applicable, and shall be disclosed by the health carrier's pharmacy benefits
32 manager to the carrier.

33 (c) Only the pharmacy provider that dispensed the prescription drug may retain the
34 payment described in this paragraph.

35 (d) A pharmacy provider shall not be denied payment or be subject to a reduced payment
36 retroactively unless the original claim was submitted fraudulently or in error.

1 I. A health carrier, or a pharmacy benefits manager under contract with a health carrier,
2 shall establish a pharmacy and therapeutics committee. A health carrier shall require its pharmacy
3 and therapeutics committee or the pharmacy and therapeutics committee of the health carrier's
4 pharmacy benefits manager to use one or more formularies.

5 II. A health carrier, or a pharmacy benefits manager under contract with a health carrier,
6 shall not allow a person with a conflict of interest, as described in subparagraphs (a) and (b), to be a
7 member of its pharmacy and therapeutics committee. A person shall not serve as a member of a
8 pharmacy and therapeutics committee if the person:

9 (a) Is employed, or was employed within the preceding year, by a pharmaceutical
10 manufacturer, developer, labeler, wholesaler, or distributor; or

11 (b) Receives compensation, or received compensation within the preceding year, from a
12 pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor.

13 III. A health carrier, or a pharmacy benefits manager under contract with a health carrier,
14 shall prohibit its pharmacy and therapeutics committee or any member of the committee from
15 receiving any compensation from a pharmaceutical manufacturer, developer, labeler, wholesaler, or
16 distributor.

17 402-O:5 Treatment of Pharmacy Benefits Manager Compensation.

18 I. In this section:

19 (a) "Anticipated loss ratio" means the ratio of the present value of the future benefits
20 payments to the present value of the future premiums of a policy form over the entire period for
21 which rates are computed to provide health insurance coverage.

22 (b) "Pharmacy benefits manager compensation" means the difference between:

23 (1) The value of payments made by a health carrier of a health plan to its pharmacy
24 benefits manager; and

25 (2) The value of payments made by the pharmacy benefits manager to dispensing
26 pharmacists for the provision of prescription drugs or pharmacy services with regard to pharmacy
27 benefits covered by the health benefit plan.

28 II.(a) If a health carrier uses a pharmacy benefits manager to administer or manage
29 prescription drug benefits provided for the benefit of covered persons, for purposes of calculating a
30 carrier's anticipated loss ratio, any pharmacy benefits manager compensation:

31 (1) Constitutes an administrative cost incurred by the carrier in connection with a
32 health benefit plan; and

33 (2) May not constitute a benefit provided under a health benefit plan.

34 (b) A health carrier shall claim only the amounts paid by the pharmacy benefits
35 manager to a pharmacy or pharmacist as an incurred claim.

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1 III. Each rate filing submitted by a health carrier with respect to a health benefit plan that
2 provides coverage for prescription drugs or pharmacy services that is administered or managed by a
3 pharmacy benefits manager shall include:

4 (a) A memorandum prepared by a qualified actuary describing the calculation of the
5 pharmacy benefits manager compensation; and

6 (b) Such records and supporting information as the commissioner reasonably determines
7 is necessary to confirm the calculation of the pharmacy benefits manager compensation.

8 IV. Upon request, a health carrier shall provide any records to the commissioner that relate
9 to the calculation of the pharmacy benefits manager compensation.

10 V. A pharmacy benefits manager shall provide any necessary documentation requested by a
11 health carrier that relates to pharmacy benefits manager compensation in order to comply with the
12 requirements of this section.

13 6 Managed Care Law. Amend RSA 420-J:8, XV(b)(3) to read as follows:

14 (3) Review and make necessary adjustments to the maximum allowable cost for
15 every drug for which the price has changed at least every [14] 7 days.

16 7 New Subdivision; New Hampshire Prescription Drug Competitive Marketplace. Amend RSA
17 21-I by inserting after section 95 the following new subdivision:

New Hampshire Prescription Drug Competitive Marketplace

19 21-I:96 Purpose and Intent. The purpose and intent of this subdivision is to authorize the
20 commissioner of the department of administrative services, with the approval of the governor and
21 the executive council, to establish the New Hampshire prescription drug competitive marketplace in
22 accordance with this subdivision. The objective of this subdivision is to optimize prescription drug
23 savings by the state of New Hampshire through the following:

24 I. Adoption of a dynamically competitive reverse auction process for the state health plan
25 selection of pharmacy benefit managers (PBM).

26 II. Ongoing, real-time electronic review and validation of PBM claims invoices as the
27 foundation for reconciling pharmacy bills.

28 III. Conduct of market checks using technology driven evaluation of the incumbent PBM's
29 prescription drug pricing based on benchmark comparators.

30 21-I:97 Definitions. In this subdivision:

31 I. "Department" means the department of administrative services.

32 II. "Pharmacy benefits manager" means a person, business, or other entity, including a
33 wholly or partially owned or controlled subsidiary of a pharmacy benefits manager, that, pursuant to
34 a contract with the health carrier or self-funded health benefit plan, manages the prescription drug
35 coverage provided by the health carrier or self-funded health benefit plan, including, but not limited
36 to, providing claims processing services for prescription drugs, performing drug utilization review,
37 processing drug prior authorization requests, adjudication of grievances or appeals related to

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1 prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered
2 prescription drugs.

3 III. "PBM reverse auction" means an automated, transparent, and dynamically competitive
4 bidding process conducted online that starts with an opening round of bids and allows qualified PBM
5 bidders to counter-offer a lower price for as many rounds of bidding as determined by the
6 department of administrative services or its authorized representative conducting the reverse
7 auction for a multiple health plan prescription drug purchasing group.

8 IV. "Price" means the projected cost of a PBM proposal or "bid" for providing prescription
9 drug benefits pursuant to this part, to enable "apples-to-apples" comparison of the costs of competing
10 PBM proposals over the duration of the PBM services contract.

11 V. "Real-time" means within no more than 12 hours.

12 VI. "PBA" means a participant bidding agreement entered into by all participants in the
13 PBM reverse auction prior to participation therein.

14 21-I:98 New Hampshire Prescription Drug Competitive Marketplace.

15 I. Notwithstanding any provision of law to the contrary, a contract for the services of a PBM
16 for the administration of benefits under this subdivision may be procured by the department, at its
17 sole discretion, in a transparent, online competitive process, or "PBM reverse auction" as set forth in
18 this subdivision. If the department, acting in its discretion, opts to conduct such a process, it shall
19 procure, through the solicitation of proposals from qualified professional services vendors, the
20 following products and services based upon price, capabilities, and other factors as determined by
21 the department:

22 (a) Technical assistance from a technology operator with respect to all of the following:

23 (1) Evaluating the qualifications of PBM bidders.

24 (2) Conducting online-automated reverse auction services to support the department
25 or its authorized representatives in comparing the pricing for the PBM procurement.

26 (3) Providing related professional services.

27 (b) Technology platform with the required capabilities for conducting a PBM reverse
28 auction, along with the related services of a technology operator, as described in subparagraph (a).

29 The technology platform shall, at a minimum, possess the capacity to do the following:

30 (1) Conduct an automated, online, reverse auction of PBM services.

31 (2) Automate repricing of diverse and complex PBM prescription drug pricing
32 proposals to enable "apples-to-apples" comparisons of the price of PBM bids utilizing 100 percent of
33 annual prescription drug claims data available for state-funded health plans or a multiple health
34 plan prescription drug purchasing group and using code-based classification of drugs from nationally
35 accepted drug sources.

1 (3) Produce an automated report and analysis of PBM bids, including the ranking of
2 PBM bids based on the comparative costs and qualitative aspects thereof within a 48-hour time
3 period following the close of each round of reverse auction bidding.

4 (4) Perform real-time, electronic, line-by-line, claim-by-claim review of 100 percent of
5 invoiced PBM prescription drug claims, and identify all deviations from the specific terms of the
6 PBM services contract resulting from the reverse auction process.

7 (c) The contract for procurement of the technology platform and technology operator
8 services shall not be awarded to any of the following:

9 (1) A vendor that is a PBM.

10 (2) A vendor that is a subsidiary or affiliate of a PBM.

11 (3) A vendor that is managed by a PBM or receives remuneration from a PBM for
12 aggregating clients into a contractual relationship with a PBM.

13 (d) The vendor shall not outsource any part of the PBM reverse auction or the
14 automated, real-time, electronic, line-by-line, claim-by-claim review of invoiced PBM prescription
15 drug claims.

16 (e) With technical assistance and support provided by the technology operator, the
17 department or its authorized representative shall specify the terms of the PBA. The terms of the
18 PBA shall not be modified except by specific consent of the department of administrative services or
19 its authorized representatives.

20 II. When and if procured, the technology platform used to conduct the reverse auction shall
21 be repurposed over the duration of the PBM services contract as an automated pharmacy claims
22 adjudication engine to perform real-time, electronic, line-by-line, claim-by-claim review of 100
23 percent of invoiced PBM prescription drug claims, and identify all deviations from the specific terms
24 of PBM services contracts.

25 III. An entity may request in writing and subject to the approval of the commissioner to
26 participate in a joint purchasing group with the state employee and retiree group insurance program
27 for procuring for PBM services through a PBM reverse auction or otherwise. All entities
28 participating in a joint purchasing group shall share proportionally in the cost of procurement
29 including all support services.

30 IV. If the department opts, at its discretion, to conduct a transparent, online competitive
31 PBM selection process, as set forth in this subdivision, the processes and procedures set forth in this
32 section shall apply to prescription drug coverage in connection with the state employee health plan
33 for benefits under this part including for state employees, retirees, spouses, and eligible dependents
34 in accordance with the provisions of RSA 21-I:30 and any applicable collective bargaining
35 agreements. Any other state-funded health plan or self-funded municipal employee or other local
36 government employee health plan, public school employee health plans, operating individually or
37 collectively, and the health plans of the university system of New Hampshire and the community

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college system of New Hampshire may utilize the processes and procedures set forth in this section individually or collectively or as a joint purchasing group with the state employee health plan.

V. After completion of a first PBM reverse auction by the department for the administration of benefits under the state employee health plan, and at the discretion of the department, self-funded private sector employer or multi-employer health plans with substantial participation by New Hampshire employees and their dependents may be permitted to participate in a joint purchasing pool with state employees for conduct of subsequent PBM reverse auctions provided that such participation shall comply with and shall be consistent with all applicable state and federal law and requirements of ERISA.

VI. The state employee health plan and any self-funded public or private sector health plans that may be permitted to participate with the state in a joint PBM reverse auction purchasing pool shall retain full autonomy over determination of their respective prescription drug formularies and pharmacy benefit designs and shall not be required to adopt a common drug formulary or common prescription pharmacy benefit design. Any such entity or purchasing group shall agree, before participating in the PBM reverse auction, to accept the prescription drug pricing plan that is selected through the PBM reverse auction process.

VII. Any PBM providing services to the department or a self-funded health plan as described in paragraphs IV and V, shall provide the department and the plan the complete pharmacy claims data necessary to conduct the reverse auction and carry out their administrative and management duties.

VIII. The department may adopt rules, pursuant to RSA 541-A, to implement the provisions of this subdivision.

8 Severability. If any provision of sections 5-7 of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

9 New Chapter; Prescription Drug Affordability Board. Amend RSA by inserting after chapter 126-AA the following new chapter:

CHAPTER 126-BB

NEW HAMPSHIRE PRESCRIPTION DRUG AFFORDABILITY BOARD

126-BB:1 Definitions. In this chapter:

I. "Board" means the New Hampshire prescription drug affordability board.

II. "Brand-name drug" means a prescription drug marketed under a proprietary name or registered trademark name, including a biological product.

III. "Generic drug" means a prescription drug, whether identified by its chemical, proprietary, or nonproprietary name, that is not a brand-name drug and is therapeutically

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1 equivalent to a brand-name drug in dosage, safety, strength, method of consumption, quality,
2 performance, and intended use. "Generic drug" includes a biosimilar product.

3 IV. "Manufacturer" means a manufacturer of prescription drugs that are distributed in the
4 state.

5 V. "Pricing unit" means the smallest dispensable amount of a prescription drug that could
6 be dispensed.

7 VI. "Public payor" means any division of state, county, or municipal government that
8 administers a health plan for its employees or an association of state, county, or municipal
9 employers that administers a health plan for its employees.

10 VII. "Wholesale acquisition cost" means a manufacturer's listed price for sale to a wholesale
11 drug distributor or other entity that purchases a prescription drug directly from the manufacturer,
12 not including any price concessions.

13 126-BB:2 New Hampshire Prescription Drug Affordability Board Established. There is
14 established the New Hampshire prescription drug affordability board to carry out the purposes of
15 this chapter.

16 I. The board shall consist of 5 members with expertise in health care economics or clinical
17 medicine, who shall not be, or be directly related to, anyone affiliated with, employed by, or
18 representing the interests of a public payor, pharmaceutical or pharmacy company, pharmacy
19 benefits management company, or health insurance provider and who have completed a conflict of
20 interest statement. They shall be appointed as follows:

21 (a) Two members by the president of the senate. The president of the senate shall also
22 appoint one alternate board member who will participate in deliberations of the board in the event a
23 member appointed by the president of the senate elects to be recused as provided in RSA 126-BB:3.

24 (b) Two members by the speaker of the house of representatives. The speaker of the
25 house of representatives shall also appoint one alternate board member who will participate in
26 deliberations of the board in the event a member appointed by the speaker of the house of
27 representatives elects to be recused as provided in RSA 126-BB:3.

28 (c) One member by the governor. The governor shall also appoint one alternate board
29 member who shall participate in deliberations of the board in the event the member appointed by
30 the governor elects to be recused as provided in RSA 126-BB:3.

31 II. Members shall be appointed to 5-year terms. Of the initial appointees, the member
32 appointed by the governor shall serve an initial term of 5 years, one member appointed by the
33 president of the senate and one member appointed by the speaker of the house of representatives
34 shall serve an initial term of 4 years and one member appointed by the president of the senate and
35 one member appointed by the speaker of the house of representatives shall serve an initial term of 3
36 years.

37 III. A majority of board members shall constitute a quorum.

1 IV. The chair of the board shall be elected by an affirmative vote of at least 4 of the 5
2 members of the board.

3 V. Beginning no later than March 1, 2021, the board shall meet in public session at least
4 every 12 weeks to review prescription drug information and to make recommendations pursuant to
5 RSA 126-BB:5. The first meeting shall be called by the first-named appointee of the senate
6 president.

7 (a) Each public meeting shall be announced 2 weeks in advance, and materials for the
8 meeting shall be made public at least one week in advance.

9 (b) Each public meeting shall provide opportunity for comment from the public in
10 attendance at the meeting, and the board shall provide the opportunity for the public to submit
11 written comments on pending decisions.

12 (c) The board may allow expert testimony at public meetings and any meeting conducted
13 in executive session as permitted by subparagraph (d).

14 (d) Notwithstanding requirements of RSA 91-A, the board may meet in executive
15 session, except that any decision of the board shall be made in public.

16 VI. The board shall be administratively attached to the department of health and human
17 services. The board may employ an executive director who shall be a classified employee.

18 126-BB:3 Conflicts of Interest. The following provisions govern any conflict of interest for a
19 member of the board, a member of the advisory council established in RSA 126-BB:4 or any staff
20 member or contractor of the board.

21 I. When appointing a member of the board or the advisory council, the appointing authority
22 shall consider any conflict of interest disclosed by the prospective member. A member shall elect to
23 be recused from any board activity in the case in which the member or an immediate family member
24 of the member has a conflict of interest. For the purposes of this paragraph, "conflict of interest"
25 means an association, including a financial or personal association, that has the potential to bias or
26 have the appearance of biasing an individual's decisions in matters related to the board or the
27 conduct of the board's activities.

28 II. A board member or staff or contractor of the board with a conflict of interest shall elect to
29 be recused. For purposes of this paragraph, "conflict of interest" means any instance in which a
30 member of the board or an immediate family member of the member has received or could receive
31 either of the following:

32 (a) A direct financial benefit of any amount deriving from the results or findings of a
33 study or determination by or for the board; or

34 (b) A financial benefit from individuals or companies that own or manufacture
35 prescription drugs, services, or items to be studied by the board that in the aggregate exceeds \$5,000
36 per year. For purposes of this subparagraph, "financial benefit" includes honoraria, fees, stock, or
37 other financial benefit and the current value of the member's or immediate family member's already

existing stock holdings, in addition to any direct financial benefit deriving from the results or findings conducted under this section.

(c) A conflict of interest shall be disclosed in the following manner:

(1) By the board in the employment of board senior staff.

(2) By the governor, president of the senate, or speaker of the house of representatives when appointing members to the board and advisory council.

(3) By the board in describing any recusals as part of any final decision relating to a prescription drug.

(4) By the 5th day after a conflict is identified or, if a public meeting of the board will occur within that 5-day period, in advance of the public meeting.

(d) Conflicts of interest shall be publicly posted on the website of the board. The information disclosed shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent that the individual elects to be recused from participation in any activity with respect to which the potential conflict exists.

(e) The board, the advisory council, a member of the board or staff, or a contractor of the board may not accept gifts, bequests, or donations of services or property that suggest a conflict of interest or have the appearance of creating bias in the work of the board or advisory council.

(f) A member of the advisory council who accepts a gift, bequest, or donation of services or property that suggests a conflict of interest or has the appearance of creating bias in the work of the advisory council shall disclose the gift, bequest, or donation publicly.

126-BB:4 Advisory Council. A 12-member advisory council is established to advise the board on establishing annual spending targets pursuant to RSA 126-BB:5, I and determining methods for meeting those spending targets pursuant to RSA 126-BB:5, III. The advisory council shall consist of the following members:

I. The governor, or designee.

II. The commissioner of the department of administrative services, or designee.

III. The commissioner of the department of corrections, or designee.

IV. The commissioner of department of health and human services, or designee.

V. The attorney general, or designee.

VI. The director of the division of risk and benefits, department of administrative services, or designee.

VII. The president of the New Hampshire State Employees Association, or designee.

VIII. The president of the New Hampshire Education Association, or designee.

IX. The executive director of the New Hampshire Municipal Association or designee.

X. The chancellor of the university system of New Hampshire, or designee.

XI. The chancellor of the New Hampshire community college system, or designee.

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1 XII. A representative of consumer interests, appointed by the governor, who shall serve a 3-
2 year term.

3 126-BB:5 Powers and Duties of the Board. The board has the following powers and duties:

4 I.(a) Beginning with the year 2022 and in consultation with the advisory council, the board
5 shall identify strategies that optimize spending by public payors for pharmaceutical products while
6 reasonably ensuring subscriber access to needed pharmaceutical products. To achieve this goal, the
7 board shall determine annual spending targets for prescription drugs purchased by public payors
8 based upon a 10-year rolling average of the medical care services component of the United States
9 Department of Labor, Bureau of Labor Statistics Consumer Price Index, medical care services index,
10 plus a reasonable percentage for inflation and minus a spending target for pharmacy savings as
11 determined by the board.

12 (b) The board shall determine spending targets on specific prescription drugs that may
13 cause affordability challenges to enrollees in a public payor health plan. Such targets shall consider
14 any medical cost offsets achieved by utilization of the drug.

15 (c) The board shall determine which public payors are likely to exceed the spending
16 targets determined under subparagraph (a).

17 II. The board may consider the following data to accomplish its duties under this section:

18 (a) A public payor's prescription drug spending data, which the 3rd-party administrator
19 or insurer for the public payor's health plan shall provide to the board on behalf of the public payor
20 upon request notwithstanding any provision of law to the contrary, including:

21 (1) Expenditures and utilization data for prescription drugs for each plan offered by
22 a public payor.

23 (2) The formulary for each plan offered by a public payor and prescription drugs
24 common to each formulary.

25 (3) Pharmacy benefit management services and other administrative expenses of the
26 prescription drug benefit for each plan offered by a public payor.

27 (4) Enrollee cost sharing for each plan offered by a public payor.

28 (5) Aggregate net spending on the prescription drug benefit.

29 (b) Data compiled by the department of health and human services. Prescription drug
30 spending data provided to the board under this subparagraph is confidential to the same extent it is
31 confidential while in the custody of the entity that provided the data to the board.

32 III. Based upon the prescription drug spending data received under paragraph II, the board,
33 in consultation with a representative of each public payor shall determine methods for the public
34 payor to meet the spending targets established under paragraph I. While continuing to ensure
35 adequate access by subscribers to needed prescribed pharmaceutical products, the board shall
36 determine whether the following methods reduce costs to individuals purchasing prescription drugs

1 through a public payor and allow public payors to meet the spending targets established under
2 paragraph I:

3 (a) Negotiating specific rebate amounts on the prescription drugs that contribute most to
4 spending that exceeds the spending targets.

5 (b) Changing a formulary when sufficient rebates cannot be secured under
6 subparagraph (a).

7 (c) Establishing a common prescription drug formulary for all public payors.

8 (d) Prohibiting health insurance carriers in the state administering benefits for a public
9 payor from offering on their formularies prescription drugs when the method described in
10 subparagraph (b) is implemented.

11 (e) Purchasing prescription drugs in bulk or through a single purchasing agreement for
12 use among public payors.

13 (f) Collaborating with other states and state prescription drug purchasing consortia to
14 purchase prescription drugs in bulk or to jointly negotiate rebates.

15 (g) Allowing health insurance carriers providing coverage to small businesses and
16 individuals in the state to participate in the public payor prescription drug benefit for a fee.

17 (h) Procuring common expert services for public payor, including but not limited to
18 pharmacy benefit management services and actuarial services.

19 IV. By November 1, 2020 and annually thereafter, the board shall report its
20 recommendations, including prescription drug spending targets, their strategies for optimization of
21 affordability of prescription drugs for the state and all of its residents, the progress of implementing
22 those recommendations, as well as the annual net spending by public payors on prescription
23 pharmaceutical products as a measure of the efficacy of implementation of those recommendations to
24 date, to the standing committees of the general court with jurisdiction over health coverage and
25 insurance matters and to the governor. This report shall also contain the following information
26 about prescription drugs, both brand name and generic:

27 (a) The 25 most frequently prescribed drugs in the state;

28 (b) The 25 costliest drugs as determined by the total amount spent on those drugs in the
29 state; and

30 (c) The 25 drugs with the highest year-over-year cost increases as determined by the
31 total amount spent on those drugs in the state.

32 V. The board may apply for and receive funds, grants, or contracts from public and private
33 sources.

34 126-BB:6 Rulemaking. The board shall adopt rules under RSA 541-A for the following:

35 I. Procedures for drug price transparency as required under RSA 126-BB:7.

36 II. The adoption of all fees under RSA 126-BB:8.

37 III. Proceedings for assessing civil fines under RSA 126-BB:10.

IV. Any other matter required to implement this chapter.

126-BB:7 Drug Price Transparency; Non-disclosure Requirements.

I. The board shall develop and implement policies and procedures for its collection, processing, storage, and analysis of clinical, financial, quality restructuring and prescription drug price data for the following purposes:

(a) To use, build, and improve upon and coordinate existing data sources and measurement efforts through the integration of data systems and standardization of concepts.

(b) To coordinate the development of a linked public and private sector information system.

(c) To emphasize data that is useful, relevant, and not duplicative of existing data.

(d) To minimize the burden on those providing data.

(e) To preserve the reliability, accuracy, and integrity of collected data.

II. The board shall adopt rules to ensure that:

(a) Payors, providers, prescription drug manufacturers, wholesale drug distributors, and pharmacy benefits managers file data as required by RSA 126-BB:9.

(b) Users that obtain health data and information from the board safeguard the identification of patients and health care practitioners.

(c) Payors, providers, prescription drug manufacturers, wholesale drug distributors, and pharmacy benefits managers pay all assessments as required by RSA 126-BB:8.

(d)(1) Only the board and employees assigned to the board may access the information received pursuant to this chapter and only for purpose of effectuating the powers and duties granted the board by this chapter. The board shall limit access to any information that it receives pursuant to this chapter to the smallest number of employees and other personnel possible; and all such individuals shall, as a condition of employment, be required to execute non-disclosure agreements under which they are restricted from disclosing any information they may receive in connection with this chapter during their employment term and in perpetuity post-employment.

(2) If the board, its members, employees, or personnel willfully shares or discloses for unauthorized purposes information that is trade secret information, confidential, commercial or proprietary information, or information designated as "confidential" by the owner of the information, the board or the individual who made the unauthorized disclosure may be subject to any penalties available under federal and state laws, including trade secret misappropriation laws, to the extent permitted by law.

126-BB:8 Funding; Assessment of Fees.

I. The expenses and cost of operation of the board shall be funded by reasonable user fees and assessments determined in rules adopted by the board.

(a) Fees may be charged for the reasonable costs of duplicating, mailing, publishing, and supplies.

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(b) Reasonable user fees shall be charged on a sliding scale for the right to access and use the health data and information available from the board. Fees may be charged for services provided to the department on a contractual basis. Fees may be reduced or waived for users that demonstrate a plan to use the data or information in research of general value to the public health or inability to pay the scheduled fees, as provided by rules adopted by the board.

(c) Annual assessments of not less than \$100 assessed against the following entities:

(1) Health insurance carriers and health maintenance organizations on the basis of the total annual health care premium.

(2) Third-party administrators.

(3) Health carriers that provide only administrative services for a plan sponsor.

(4) Pharmacy benefits managers that process and pay claims on the basis of claims processed or paid for each plan sponsor.

(d) Health care policies issued for specified disease, accident, injury, hospital indemnity, disability, long-term care or other limited benefit health insurance policies are not subject to assessment under subparagraph (c). For purposes of this paragraph, policies issued for dental services are not considered to be limited benefit health insurance policies.

(e) Annual assessments of not less than \$500 assessed by the board against prescription drug manufacturers, wholesale drug distributors, and pharmacy benefits managers.

II. The aggregate level of annual assessments under subparagraphs (c) and (e) shall be an amount sufficient to meet the board's expenditures authorized. The board may waive assessments otherwise due under subparagraphs (c) and (e) when a waiver is determined to be in the interests of the board and the parties to be assessed.

126-BB:9 Drug Price Notifications and Disclosures; Confidentiality; Registration.

I. No later than January 30, 2021 and annually thereafter, a manufacturer shall notify the board when the manufacturer has during the prior calendar year:

(a) Increased the wholesale acquisition cost of a brand-name drug by more than 20 percent per pricing unit;

(b) Increased the wholesale acquisition cost of a generic drug that costs at least \$10 per pricing unit by more than 20 percent per pricing unit; or

(c) Introduced a new drug for distribution in this state when the wholesale acquisition cost is greater than the amount that would cause the drug to be considered a specialty drug under the Medicare Part D program. For the purposes of this section, "Medicare Part D" means prescription drug benefit in accordance with the requirements of the federal Medicare Prescription Drug Improvement and Modernization Act of 2003.

II.(a) To develop the report under paragraph VIII, the board shall first assess public information that is readily available. To the extent there is no public information or not enough

1 public information readily available to the board to produce its report, the board may request
2 information from:

3 (1) The manufacturer that provided notice to the board pursuant to paragraph I;

4 (2) A pharmacy benefit manager or health insurance carrier providing services
5 involving the drug that is the subject of the notification provided pursuant to paragraph I.

6 (b) Once the board requests information of a manufacturer, pharmacy benefit manager,
7 or health insurance carrier, the entity shall have 60 days to produce the requested information
8 regarding the prescription drug that is the subject of the request. If, after a complete review of all
9 information and data available to the board or as received from the entities, the board makes a
10 determination that additional data is required for a particular prescription drug to produce the
11 report under paragraph VIII, the board may request that additional information from wholesale
12 drug distributors that distribute the prescription drug that is the subject of the report. Once the
13 board requests information of a wholesale drug distributor, it shall have 60 days to produce
14 information regarding the prescription drug that is the subject of the request.

15 III.(a) Upon receipt of a request from the board relating to a specific prescription drug for
16 which notice was provided pursuant to paragraphs I and II, a manufacturer shall provide to the
17 board, in a form and manner specified by the board, (i) a written, narrative description, suitable for
18 public release, of all factors that caused the increase in the wholesale acquisition cost of the listed
19 outpatient prescription drug, and (ii) aggregate, company-level research and development costs and
20 such other capital expenditures that the board, in its discretion, deems relevant for the most recent
21 year for which final audited data are available.

22 (b) The data that a pharmaceutical manufacturer submits to the board under this
23 section may be limited to the information and data that the pharmaceutical manufacturer includes
24 in such pharmaceutical manufacturer's annual consolidated report on Securities and Exchange
25 Commission Form 10-K, or any other public disclosure.

26 (c) The board shall establish a standardized form for reporting information and data
27 pursuant to this section after consulting with pharmaceutical manufacturers. The form shall be
28 designed to minimize the administrative burden and cost of reporting on the office and
29 pharmaceutical manufacturers.

30 (d) Upon a request from the board relating to a specific prescription drug for which
31 notice was provided pursuant to paragraphs I and II, a pharmacy benefit manager or wholesaler
32 shall provide:

33 (1) The dollar amount of all rebates or fees concerning the drug collected from the
34 manufacturer that were covered by such health carriers during such calendar year; and

35 (2) The dollar amount of all rebates and fees, excluding any portion of the rebates or
36 fees received by health carriers, concerning the drug collected from the manufacturer.

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1 (e) The board shall establish a standardized form for reporting information pursuant to
2 subparagraph (d) after consultation with pharmacy benefits managers and wholesalers. The form
3 shall be designed to minimize the administrative burden and cost of reporting on pharmacy benefits
4 managers and wholesalers.

5 IV. Information provided to the board as required by this section by a manufacturer,
6 wholesale drug distributor, or pharmacy benefits manager that has not been publicly reported is
7 confidential and not a public record under RSA 91-A, except that the board may share information:

8 (a) With the insurance department, to the extent necessary for the department to
9 enforce insurance laws, as long as any information shared is kept confidential; and

10 (b) As long as it is not released in a manner that represents a breach of confidential
11 information provided by a manufacturer, wholesale drug distributor, or pharmacy benefits manager.

12 V. Beginning January 1, 2021, a manufacturer, pharmacy benefits manager, and wholesale
13 drug distributor subject to this section shall register annually with the board in a manner prescribed
14 by the board.

15 VI. A manufacturer, wholesale drug distributor, or pharmacy benefits manager that submits
16 a notification or report to the board pursuant to this section shall submit with the notification or
17 report a signed written certification of the notification's or report's accuracy. Any confidential or
18 proprietary information contained within such notification or report shall be clearly identified as
19 such. Any breach of confidential information not so identified shall not be subject to RSA 126-BB:7,
20 II(d).

21 VII.(a) The board may audit the data submitted by a manufacturer, wholesale drug
22 distributor, or pharmacy benefits manager pursuant to this section. The costs of the audit shall be
23 paid for by the manufacturer, wholesale drug distributor, or pharmacy benefits manager.

24 (b) The board may require a manufacturer, wholesale drug distributor, or pharmacy
25 benefits manager subject to this section to develop a corrective action plan to correct any deficiencies
26 the board finds with the manufacturer's, wholesale drug distributor's, or pharmacy benefits
27 manager's compliance with this section.

28 VIII. Beginning November 1, 2021 and annually thereafter, the board shall produce and post
29 on its publicly accessible website an annual report, including information developed from the
30 notifications and disclosures received pursuant to this section on trends in the cost of prescription
31 drugs, analysis of manufacturer prices and price increases, the major components of prescription
32 drug pricing along the supply chain and the impacts on insurance premiums and cost sharing, and
33 any other information the board determines is relevant to providing greater consumer awareness of
34 the factors contributing to the cost of prescription drugs in the state. The report may not disclose
35 information attributable to any particular manufacturer, wholesale drug distributor, or pharmacy
36 benefits manager subject to this section and may not make public any information that is
37 confidential. The board shall submit the report required by this section to the standing committees

1 of the general court with jurisdiction over health data reporting and prescription drug matters and
2 the governor.

3 126-BB:10 Civil Penalties. When a person or entity that is a health care facility payor,
4 prescription drug manufacturer, wholesale drug distributor, or pharmacy benefits manager violates
5 any requirement of this chapter, that person or entity commits a civil violation for which a fine of not
6 more than \$1,000 per day may be imposed. A fine imposed under this paragraph may not exceed
7 \$25,000 for any one occurrence.

8 10 New Chapter; Wholesale Prescription Drug Importation Program. Amend RSA by inserting
9 after chapter 126-BB the following new chapter:

10 CHAPTER 126-CC

11 WHOLESALE PRESCRIPTION DRUG IMPORTATION PROGRAM

12 126-CC:1 Definitions. In this chapter:

13 I. "Commissioner" means the commissioner of the department of health and human services.

14 II. "Department" means the department of health and human services.

15 III. "Program" means the wholesale prescription drug importation program.

16 126-CC:2 Design of Program: Rulemaking.

17 I. There is hereby established the wholesale prescription drug importation program, referred
18 to in this chapter as the "program," to provide for the wholesale importation of prescription drugs
19 from Canada by or on behalf of the state.

20 II. The department, in consultation with appropriate federal and other state agencies and
21 interested parties, shall design the program to comply with the applicable requirements of 21 U.S.C.
22 section 384, including requirements regarding safety and cost savings. The program design shall:

23 (a) Designate a state agency to become a licensed drug wholesaler or to contract with a
24 licensed drug wholesaler in order to seek federal certification and approval, pursuant to RSA 126-
25 CC:3, to import safe prescription drugs and provide cost savings to consumers in the state.

26 (b) Use prescription drug suppliers in Canada regulated under the laws of Canada or of
27 one or more Canadian provinces, or both.

28 (c) Ensure that only prescription drugs that can meet the federal Food and Drug
29 Administration's safety, effectiveness and other standards are imported by or on behalf of the state.

30 (d) Import only those prescription drugs expected to generate substantial cost savings
31 for consumers in the state.

32 (e) Ensure that the program complies with the transaction and tracing requirements of
33 21 U.S.C. sections 360eee and 360eee-1 to the extent feasible and practical prior to imported
34 prescription drugs coming into the possession of the licensed United States drug wholesaler and that
35 the program complies fully with those federal requirements after imported prescription drugs are in
36 the possession of the licensed drug wholesaler.

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1 (f) Prohibit the distribution, dispensing or sale of imported prescription drugs outside of
2 the state.

3 (g) Recommend a method to finance the program which will not jeopardize consumer
4 cost savings.

5 (h) Include an audit function.

6 III. The commissioner shall adopt rules pursuant to RSA 541-A, to design the program in
7 accordance with this chapter.

8 IV. The department shall submit a request for approval and certification of the program to
9 the United States Department of Health and Human Services on or before February 1, 2021.

10 126-CC:3 Requirements of Program. Prior to operating the program, the state agency
11 designated to oversee the program pursuant to this chapter shall:

12 I. Become a licensed drug wholesaler or enter into a contract with a licensed drug
13 wholesaler in the state.

14 II. Contract with one or more distributors licensed in the state.

15 III. Contract with one or more licensed and regulated prescription drug suppliers in Canada.

16 IV. Seek the appropriate federal approvals, exemptions, or agreements, or a combination
17 thereof, as needed to enable all covered entities enrolled in or eligible for the federal 340B Drug
18 Pricing Program to participate in the program to the fullest extent possible without jeopardizing
19 their eligibility for the 340B Program.

20 V. Consult with health insurance carriers, employers, pharmacies, pharmacists, health care
21 providers and consumers.

22 VI. Develop a registration process for health insurance carriers, pharmacies and health care
23 providers authorized to prescribe and administer prescription drugs that are willing to participate in
24 the program.

25 VII. Create a publicly accessible website for listing the prices of prescription drugs to be
26 imported under the program.

27 VIII. Create an outreach and marketing plan to work with health carriers, provider
28 associations to generate public awareness of the program.

29 IX. Develop a 2-year audit work plan.

30 X. Conduct any other activity determined necessary to successfully implement and operate
31 the program.

32 126-CC:4 Annual Report. Beginning November 1, 2021, and each November 1 thereafter, the
33 department or other designated state agency shall submit an annual report to the chairperson of the
34 health, human services and elderly affairs committee, the speaker of the house of representatives,
35 the president of the senate, the house clerk, the senate clerk, the governor, and the state library
36 relative to:

37 I. The prescription drugs included in the program.

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1 II. The number of participating pharmacies, health care providers, and health insurance
2 carriers.

3 III. The number of prescription drugs dispensed through the program.

4 IV. The estimated cost savings to consumers, health insurance carriers, employers, and the
5 state during the previous calendar year and to date.

6 V. Information regarding implementation of the audit work plan and audit findings.

7 VI. Any other information the department, or other state agency designated to oversee the
8 program pursuant to this chapter, deems relevant.

9 11 Consumer Protection: Acts Unlawful. Amend RSA 358-A:2, XIV to read as follows:

10 XIV. Pricing of goods or services in a manner that tends to create or maintain a monopoly, or
11 otherwise harm competition, ***including the pricing of generic prescription drugs.***

12 12 New Paragraph; Managed Care Law; Prescription Drugs. Amend RSA 420-J:7-b by inserting
13 after paragraph II-a the following new paragraph:

14 II-b. Every health benefit plan that provides prescription drug benefits and requires prior
15 authorization for covered drugs in the formulary shall respond to a prior authorization request
16 within 48 hours. The prior authorization process shall begin when the prescribing provider has
17 submitted a request to the health carrier or pharmacy benefits manager. A prescription that
18 requires a prior authorization for coverage shall be considered approved if the prior authorization
19 process exceeds 48 hours.

20 13 New Section; Accident and Health Insurance; Coverage for Epinephrine Auto-Injectors;
21 Individual. Amend RSA 415 by inserting after section 6-x the following new section:

22 415:6-y Coverage for Epinephrine Auto-Injectors. Each insurer that issues or renews any
23 individual policy of accident or health insurance providing benefits for medical or hospital expenses,
24 shall provide to certificate holders of such insurance, who are residents of this state, coverage for the
25 cost of epinephrine auto-injectors. Benefits provided under this section shall not be subject to any
26 greater co-payment, deductible, or coinsurance than any other similar benefits provided by the
27 insurer and shall be subject to the terms and conditions of the policy. In this section, "epinephrine
28 auto-injector" means a single-use device used for the automatic injection of a pre-measured dosage of
29 epinephrine into the human body.

30 14 New Section; Accident and Health Insurance; Coverage for Epinephrine Auto-Injectors;
31 Group. Amend RSA 415 by inserting after section 18-bb the following new section:

32 415:18-cc Coverage for Epinephrine Auto-Injectors. Each insurer that issues or renews any
33 policy of group or blanket accident or health insurance providing benefits for medical or hospital
34 expenses, shall provide to certificate holders of such insurance, who are residents of this state,
35 coverage for the cost of epinephrine auto-injectors. Benefits provided under this section shall not be
36 subject to any greater co-payment, deductible, or coinsurance than any other similar benefits
37 provided by the insurer and shall be subject to the terms and conditions of the policy. In this section,

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1 "epinephrine auto-injector" means a single-use device used for the automatic injection of a pre-
2 measured dosage of epinephrine into the human body.

3 15 Health Services Corporations; Applicable Statutes. Amend RSA 420-A:2 to read as follows:

4 420-A:2 Applicable Statutes. Every health service corporation shall be governed by this chapter
5 and the relevant provisions of RSA 161-H, and shall be exempt from this title except for the
6 provisions of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415-A, RSA 415-F, RSA 415:6,
7 II(4), RSA 415:6-g, RSA 415:6-k, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-t, RSA 415:6-u,
8 RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, **RSA 415:6-y**, RSA 415:18, V, RSA 415:18, XVI and XVII,
9 RSA 415:18, VII-a, RSA 415:18-a, RSA 415:18-i, RSA 415:18-j, RSA 415:18-o, RSA 415:18-r, RSA
10 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-y, RSA 415:18-z, RSA 415:18-aa,
11 RSA 415:18-bb, **RSA 415:18-cc**, RSA 415:22, RSA 417, RSA 417-E, RSA 420-J, and all applicable
12 provisions of title XXXVII wherein such corporations are specifically included. Every health service
13 corporation and its agents shall be subject to the fees prescribed for health service corporations
14 under RSA 400-A:29, VII.

15 16 Health Services Corporations; Applicable Statutes; Effective January 2021. Amend RSA 420-
16 A:2 to read as follows:

17 420-A:2 Applicable Statutes. Every health service corporation shall be governed by this chapter
18 and the relevant provisions of RSA 161-H, and shall be exempt from this title except for the
19 provisions of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415-A, RSA 415-F, RSA 415:6,
20 II(4), RSA 415:6-g, RSA 415:6-k, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-u, RSA 415:6-v,
21 RSA 415:6-w, RSA 415:6-x, **RSA 415:6-y**, RSA 415:18, V, RSA 415:18, XVI and XVII, RSA 415:18,
22 VII-a, RSA 415:18-a, RSA 415:18-i, RSA 415:18-j, RSA 415:18-o, RSA 415:18-r, RSA 415:18-t, RSA
23 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-z, RSA 415:18-aa, RSA 415:18-bb, **RSA 415:18-**
24 **cc**, RSA 415:22, RSA 417, RSA 417-E, RSA 420-J, and all applicable provisions of title XXXVII
25 wherein such corporations are specifically included. Every health service corporation and its agents
26 shall be subject to the fees prescribed for health service corporations under RSA 400-A:29, VII.

27 17 Health Maintenance Organizations; Statutory Construction. Amend RSA 420-B:20, III to
28 read as follows:

29 III. The requirements of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415:6-g,
30 RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-t, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA
31 415:6-x, **RSA 415:6-y**, RSA 415:18, VII-a, RSA 415:18, XVI and XVII, RSA 415:18-i, RSA 415:18-j,
32 RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-y, RSA
33 415:18-z, RSA 415:18-aa, RSA 415:18-bb, **RSA 415:18-cc**, RSA 415-A, RSA 415-F, RSA 420-G, and
34 RSA 420-J shall apply to health maintenance organizations.

35 18 Health Maintenance Organizations; Statutory Construction; Effective January 1, 2021.
36 Amend RSA 420-B:20, III to read as follows:

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1 III. The requirements of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415:6-g,
2 RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, ***RSA***
3 ***415:6-y***, RSA 415:18, VII-a, RSA 415:18, XVI and XVII, RSA 415:18-i, RSA 415:18-j, RSA 415:18-r,
4 RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-z, RSA 415:18-aa, RSA
5 415:18-bb, ***RSA 415:18-cc***, RSA 415-A, RSA 415-F, RSA 420-G, and RSA 420-J shall apply to health
6 maintenance organizations.

7 19 New Paragraph; Pharmacy Benefits Managers; Definitions. Amend RSA 402-N:1 by
8 inserting after paragraph II the following new paragraph:

9 II-a. "Contracted copayment" means the amount a covered person is required to pay as his
10 or her copayment for prescription drugs as communicated to him or her by his or her health plan,
11 usually printed on his or her insurance card.

12 20 Effective Date.

13 I. Section 9 of this act shall take effect July 1, 2020.

14 II. Sections 5 and 6 of this act shall take effect January 1, 2021.

15 III. Sections 16 and 18 of this act shall take effect January 1, 2021, at 12:04 a.m.

16 IV. Sections 1, 10, 13-15, and 17 of this act shall take effect 60 days after its passage.

17 V. The remainder of this act shall take effect upon its passage.

2020-1298s

AMENDED ANALYSIS

This bill:

- I. Requires insurers to cap the total amount for insulin for covered persons.
- II. Establishes a wholesale importation program for prescription drugs from Canada by or on behalf of the state. This bill requires the department of health and human services to design the program and obtain federal approval for the program.
- III. Regulates the maximum allowable cost for prescription drug benefits paid by health insurers or pharmacy benefit managers.
- IV. Establishes the New Hampshire prescription drug competitive marketplace.
- V. Establishes a prescription drug affordability board to determine annual public payor spending targets for prescription drugs, develop and implement policies and procedures for the collection of prescription drug price data, implement a register of drug manufacturers for drug pricing data, and establish funding for the board by reasonable user fees and assessments.
- VI. Clarifies the pricing of generic prescription drugs under the law governing consumer protection.
- VII. Clarifies the procedure for prior authorization for prescription drugs on the formulary under the managed care law.
- VIII. Requires insurance coverage for epinephrine autoinjectors.