

October 1, 2019

### Prescription Drug Cost and Transparency Bills – 2019 Session – Description and Comparison

This table briefly describes selected bills from the 2019 legislative session that address prescription drug costs and transparency, and indicates any action taken on these bills. The bills are grouped into three categories: Passed House – Enacted, Passed House – Not Enacted, and Other Bills. The table also identifies related bills that are similar in intent or concept.

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| H.F. and description | 2019 legislative action; notes on similar bills |
| Passed House - Enacted | |
| HF 182-1 (Lippert) – Drug repository.   * Requires the Board of Pharmacy to establish a drug repository program by January 1, 2020, to accept and distribute donated drugs and medical supplies. | Action: ENACTED in HHS Omnibus, 2019 First special session, chapter 9, article 9, § 7. |
| HF 485-1 (Howard) – Insulin assistance program and consumer information.   * Directs the Commissioner of Human Services to implement an insulin assistance program for eligible individuals. * Requires insulin manufacturers and wholesalers to report to the Board of Pharmacy insulin sales and distribution, and requires the board to assess a fee to pay for the insulin assistance program. * Requires the Board of Pharmacy to develop a web page for purchasing drugs at lower costs, and requires health boards to encourage their licensees to provide consumers with information on lowering drug costs. | Action: PARTLY ENACTED. Sections related to Board of Pharmacy web page and board provision of consumer information enacted as part of the HHS omnibus (first special session, chapter 9, sections 4 and 8). Insulin assistance program and manufacturer/wholesaler fee not enacted, but were included in the HHS Omnibus that passed the House (HF2414).  This bill sets up an assistance program for insulin and funds the program through fees on manufacturers and wholesalers. HF 289 and HF 284 also deal with insulin.  HF 289 requires annual reports; HF 284 allows MDH to set reimbursement levels in certain cases. |
| HF 687-1 (Bahner) – Prescription synchronization and emergency refills (includes language from HF 688 (Bahner)).   * Requires contracts between a PBM and pharmacy to allow for prescription synchronization at least once per year. * Allows one 30-day refill in emergency situations, when a prescription does not allow for refills or the time for refills has elapsed. | Action: Similar synchronization provision ENACTED as part of PBM bill, chapter 39 (HF 728). Similar emergency refill provision ENACTED in HHS omnibus (2019 first special session, chapter 9, sections 2, 3, and 6).  Synchronization language similar to § 13 of HF 728 (ENACTED), but also allows a request by guardian.  HF 923 (Howard) also addressed emergency refills. |
| HF 728 (Mann) – PBM regulation.   * § 3 requires licensure of PBMs. * §§ 4, 5, and 6 establish good faith and fair dealing, network adequacy, and price/fee/rebate transparency requirements. Require annual transparency reports to the Commissioner of Commerce. * § 7 limits PBM use of enrollee financial incentives tied to use of a pharmacy in which the PBM has an ownership interest, limits the use of quantity or refill limits that differ based on ownership interests, and limits discrimination against 340B pharmacies. * § 8 limits PBMs from requiring pharmacies to substitute a therapeutically equivalent drug with higher enrollee out-of-pocket costs. * § 9 requires disclosure of specialty pharmacy and network retail pharmacy enrollee out-of-pocket costs. * § 10 requires disclosure of preferred pharmacy and nonpreferred network pharmacy enrollee out-of-pocket costs. * § 11 requires PBMs to provide pharmacies with information on maximum allowable cost pricing. * § 13 requires contracts between a PBM and a pharmacy to allow synchronization at least once per year. * § 14 (a) prohibits gag clauses between a PBM or health carrier and a pharmacy, related to provision of information on treatment alternatives, utilization review and the approval process, and financial incentives. * (b) Requires pharmacists to provide enrollees with information on the enrollee’s total cost of drugs, when the drug is paid for by the employer plan, health carrier, or PBM. * (c) Prohibits a PBM or health carrier from prohibiting a pharmacy from discussing information on costs, including copayments and the usual and customary price. * (d) Provides that a PBM or health carrier must not prohibit a pharmacy from discussing alternative drugs or alternative methods of purchasing the drug, including paying the usual and customary price out-of-pocket. * § 15 provides that a PBM or health carrier must not require an enrollee to pay at the point of sale an amount greater than the lesser of: (1) the applicable copayment; (2) the allowable claim amount; or (3) the amount paid without using a health benefit. * § 17 requires mail order pharmacies to fill certain specialty drug prescriptions in seven business days. * § 19 allows substitution of therapeutically equivalent and interchangeable drugs covered under an enrollee’s plan, if the drug prescribed is not covered. | Action: ENACTED as chapter 39.  HF 687 contains prescription synchronization language similar to § 13, but includes language allowing requests by guardians.  Gag clause language in § 14 is broad in scope relative to HF 149, and includes general language on alternative methods of treatment, utilization review, etc.  Enrollee payment language in § 15 similar to HF 743.  HF 2099 (Brand) is similar to § 17 but requires specialty drug prescriptions to be filled in five business days. |
| HF 892 (Stephenson) – Pharmacy licensure requirements (dialysis manufacturer).   * Exempts from pharmacy licensure a manufacturer, wholesaler, or third-party logistics provider that distributes dialysate or devices for home peritoneal dialysis for patients with end-stage renal disease, if certain requirements are met. | Action: ENACTED as chapter 44. |
| HF 2414 (Liebling) – Drug provisions in Health and Human Services Omnibus.   * § 1 exempts infusion drugs from Medicare anti-kickback provisions. * §§ 2,3,5, and 6 – emergency refills (see HF 687 (Bahner)). * §§ 4, 8 – Board of Pharmacy drug cost information on website (see HF 485 (Howard)). * § 7 – drug repository program (see HF 182 (Lippert)). | Action: ENACTED during special session as 2019 first special session, chapter 9, article 9. |
| Passed House – Not Enacted | |
| HF 3-1, as amended (Liebling) – Drug provisions in the OneCare bill.  Requires DHS to:   * administer a pharmacy benefit directly for MA and MinnesotaCare, and for the OneCare Buy-in; * negotiate drug rebates or discounts directly with manufacturers, or through a contract with a vendor, and report these discounts, rebates, and savings to the legislature; * exclude prescription drugs from MA and MinnesotaCare managed care contracts; and   develop a plan for an outpatient pharmacy benefit to be administered by DHS for enrollees of health plan companies that choose to participate. | Action: passed three committees; in HHS Finance. Also passed the House as part of the HHS Omnibus (HF 2414), but not included in the HHS Omnibus that was passed during special session. |
| HF 4-2 (Lesch) – Price gouging.   * Prohibits drug manufacturers and wholesalers from charging unconscionable prices for essential prescription drugs. Essential prescription drugs are broadly defined to include drugs on the MA or Medicare Part D formularies or designated by DHS, and for which certain price thresholds are met. * Requires DHS, health plan companies, and the Board of Pharmacy to notify the Attorney General of certain price increases for essential drugs. * Allows the Attorney General to bring actions for alleged violations. Also provides for a private right of action. * Allows the Board of Pharmacy to assess civil penalties. | Action: passed three committees; in HHS Finance. Also passed the House as part of the HHS Omnibus (HF 2414), but not included in the HHS Omnibus that was passed during special session.  Also see HF 1246. Both HF 4 and HF 1246 apply to a wide range of drugs and require reporting of price, cost, and other information for drugs that exceed certain price or price increase thresholds. These thresholds are different in the two bills. For example, HF 4 uses an $80 per course of treatment threshold for determining an essential drug and requires various entities to notify the Attorney General of a 15 percent or higher increase in the price of an essential drug over a year. HF 1246, for existing drugs, requires reporting of price and other information for drugs that exceed a $40 per course of treatment threshold and exceed price increase thresholds of 10 percent over a 12-month period and 16 percent over a 24-month period.  The reporting requirements of HF 4 and HF 1246 have different purposes. Under HF 4, reporting would potentially allow the Attorney General to bring actions against manufacturers or wholesalers for violations of the prohibition on unconscionable price increases. Under HF 1246, reporting would be a means for the Department of Health to make information on drug costs and prices public. |
| HF 1246-1 (Morrison) – Prescription drug price transparency.   * Requires drug manufacturers to report, to the Commissioner of Commerce, specified information on drug costs and prices, for: (1) existing drugs for which the price increase exceeds thresholds; (2) new drugs meeting price thresholds; and (3) newly acquired drugs meeting price thresholds. * MDH is to post this information and the list of drugs on the agency website. MDH can assess penalties for failure to report. MDH to also report annually to the legislature. | Action: passed three committees; in HHS Finance. Also passed the House as part of the HHS Omnibus (HF 2414), but not included in the HHS Omnibus that was passed during special session.  Also see HF 4 and HF 289.  HF 704 requires reporting of certain cost information for drugs with a WAC of $10,000 or more annually or per course of treatment. |
| HF 1257 (Cantrell) – Prescription drug formulary transparency.   * Requires health plan companies to make formularies available to the public. * Limits the extent to which a health plan company can remove a brand name drug from a formulary or place that drug in a higher cost tier, or change utilization review requirements, during an enrollee’s contract year. | Action: passed two committees; in HHS Finance. Also passed the House as part of the HHS Omnibus (HF 2414), but not included in the HHS Omnibus that was passed during special session.  Also see HF 288, which is limited to formulary disclosure for insulin and related supplies. |
| Other Bills | |
| HF 149-2 (Bahner) – Gag clause.   * A contract between an employer plan or health plan company, and its PBM, cannot prohibit a pharmacist from informing a patient when the amount the patient would pay under the plan benefit would be greater than paying out-of-pocket at the pharmacy’s usual and customary price. * Also modifies current law requirements on price information that a pharmacy must provide to patients. | Action: passed two committees to floor; returned to Commerce.  Similar to HF 743 and HF 728 (ENACTED as chapter 39), but narrower in that it focuses on providing information about paying out-of-pocket at the usual and customary price. |
| HF 284-1 (Halverson) – Cost review of insulin products; authority to set reimbursement level.   * Requires the Commissioner of Health to review the cost of insulin products, as reported by manufacturers. * If the commissioner determines that spending on insulin creates excess costs to purchasers and consumers, requires the commissioner to establish a maximum level of reimbursement, to limit manufacturer profits to not more than 50 percent. * The Attorney General may pursue remedies if there is noncompliance with the reimbursement requirements. | Action: passed two committees; in Civil Law.  HF 284 and HF 289 both deal with prices for insulin/diabetes drugs and require manufacturer reporting. HF 289 requires annual reports; HF 284 allows MDH to set reimbursement levels in certain cases.  HF 1668 would allow the setting of reimbursement levels for all drugs, if certain conditions are met. |
| HF 288-1 (Masin) – Formulary transparency for insulin and supplies.   * Requires a health plan company to disclose to enrollees upon request the brands of insulin and supplies covered under a health plan. * Prohibits a health plan company from removing from coverage a brand or supply during an enrollee’s contract year. | Action: passed two committees; in HHS Finance.  Similar in general intent to HF 1257, but limited to insulin and supplies. |
| HF 289-1 (Mann) – Cost transparency for diabetes drugs.   * Requires the Commissioner of Health to annually compile a list of drugs essential to treat diabetes, and those diabetes drugs whose cost has increased above thresholds. * Requires manufacturers to provide the commissioner with cost and other information for drugs on the list, and information on factors leading to cost increases. * Requires PBMs to report certain rebate information for these drugs. * Requires health plan companies to submit to the Commissioner of Commerce information on premiums, spending on essential diabetes drugs, and the use of PBMs. * Requires pharmacies to report information on payments made and received for these drugs. * Requires the commissioner to issue annual reports on prices for drugs on the list, reasons for increases, effect on drug spending, and recommendations on lowering cost of diabetes drugs. | Status: passed two committees; in HHS Finance.  Similar in general intent to HF 1246, but limited to drugs for diabetes. HF 289 requires MDH to identify essential diabetes drugs for which other entities must report price, cost, rebate, and other information, while HF 1246 requires reporting of information about drug prices generally based on whether the price increase exceeds specific thresholds.  HF 284 allows MDH to review the cost of insulin products and set reimbursement levels.  HF 704 requires manufacturer cost reporting for high cost prescription drugs generally. |
| HF 704 (Morrison) – Prescription drug transparency.   * Requires manufacturers to report specified cost information on qualifying drugs (those with a WAC of $10,000 or more annually or per course of treatment) to the Commissioner of Health. * Requires the commissioner to annually report this information to the legislature, and to convene an advisory committee. | Action: no hearing.  HF 289 requires manufacturer cost reporting for insulin.  HF 1246 requires reporting of certain price increases, and certain prices for new or acquired drugs.  HF 2518 (Munson) is identical. |
| HF 743-1 (Bahner) – Allowable cost to consumers.   * Prohibits a health plan company or PBM from requiring an individual to pay an amount greater than: (1) the applicable copayment; (2) the allowable claim amount; or (3) the amount paid without using a health benefit. | Action: passed two committees; in HHS Finance.  Similar to provisions in HF 728 (ENACTED as chapter 39). |
| HF 1523-1 (Cantrell) – Drug purchasing program.   * Requires DHS to administer a prescription drug purchasing program for MA and MinnesotaCare enrollees, and enrollees purchasing individual coverage from private health insurers that choose to participate. * DHS would develop a preferred drug list and negotiate price discounts and rebates. * Exempts infusion drugs and related services and supplies from Medicare anti-kickback provisions. | Action: passed two committees; in HHS Finance.  Infusion drug exemption ENACTED in HHS Omnibus (2019 first special session, chapter 9, article 9, § 1. |
| HF 1668 (Pryor) – Drug affordability commission and price setting.   * Establishes a Prescription Drug Affordability Commission and a related advisory council. * Requires drug manufacturers to notify the commission of certain drug price increases. * Allows the commission to initiate drug price reviews and to set maximum levels of reimbursement. | Action: no hearing.  HF 284 would allow setting of reimbursement levels for insulin products. |
| HF 1768 (Albright) – Information on manufacturer assistance programs.   * Requires pharmacists to provide information about drug manufacturer financial assistance programs, when dispensing a drug to treat a chronic illness or condition. | Action: no hearing.  HF 2414 (language ENACTED during special session) would require information on manufacturer financial assistance programs to be included on the Board of Pharmacy website. |
| HF 2099 (Brand) – Specialty drug prescriptions.   * Requires mail order pharmacies to fill certain specialty drug prescriptions in five business days. | Action: no hearing.  Similar language ENACTED as part of chapter 39/HF 728, with requirement that prescription be filled in seven business days. |
| HF 2819 (Howard) – Tax on excess drug prices.   * Imposes a tax of an unspecified percentage on a manufacturer’s excess price amount for a prescription drug. * Defines excess price amount as the difference between the current average manufacturer’s price for a drug and a price tied to 2014 or the year of drug introduction, adjusted by the change in the CPI for medical care. | Action: no hearing. |