HOUSE . . . . . No. 2683

By Ms. Jehlen of Somerville, petition of Patricia D. Jehlen and others relative to establishing a prescription drug pricing program. Public Health.

The Commonwealth of Massachusetts

PETITION OF:

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In the Year Two Thousand and Five.

AN ACT ESTABLISHING THE MASSACHUSETTS PRESCRIPTION DRUG FAIR PRICING PROGRAM.

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

SECTION 1. Chapter 118E of the General Laws is hereby amended by inserting after section 12 the following sections:

Section 12A. Consumer Protection Rules; Prior Authorization of Prescription Drugs.

(a) Any prior authorization process required by the division before it authorizes coverage for a prescription drug shall comply with the consumer protections in this section and with 42 U.S.C. section 1396r-8(d).

(b) Coverage for a prescription drug that is not covered by the division without prior authorization shall be authorized if a patient's health care provider certifies, in a manner determined by the division, that:

(i) the drug is medically necessary; and

(ii) in the case of a prescription drug that is not the preferred choice in a therapeutic category on the preferred drug list,

(A) the preferred choice has not been effective, or with reasonable certainty is not expected to be effective in treating the patient's condition; or

(B) the preferred choice causes or is reasonably expected to cause adverse or harmful reactions in the patient.

(c) The prescriber's certification concerning whether a particular drug has been ineffective, is expected to be ineffective in treating the patient, or is expected to cause an adverse or harmful reaction shall be final.

(d) (1) The division's prior authorization process shall be designed to minimize administrative burdens on prescribers, pharmacists, and consumers.

(2) The prior authorization process shall ensure real-time receipt of requests, by telephone, voice mail, facsimile, electronic transmission, or mail on a 24-hour basis, seven days a week.

(3) The prior authorization process shall provide an in-person response to emergency requests by a prescriber with telephone answering queues that do not exceed 10 minutes.

(4) Any request for authorization or approval of a drug that the prescriber indicates, including the clinical reasons for the request, is for an emergency or urgent condition shall be responded to in no more than 4 hours from the time the program or participating health benefit plan receives the request.

(5) In emergency circumstances, or if the response to a request for prior authorization is not provided within the time period established in subdivision (4) of this subsection, a 72-hour supply of the drug prescribed shall be deemed to be authorized by the program or the participating health benefit plan, provided it is a prescription drug approved by the United States Food and Drug Administration, and provided, for drugs dispensed to a Medicaid beneficiary, it is subject to a rebate agreement with the Centers for Medicare and Medicaid Services.

(6) The division shall provide to participating providers a prior authorization request form designed to permit the prescriber to make prior authorization requests in advance of the need to fill the prescription, and designed to be completed without unnecessary delay. The form shall be capable of being stamped with information relating to the participating provider and, if feasible, at least one form capable of being copied shall contain known patient information.

(e) The division's prior authorization process shall require that the prescriber, not the pharmacy, request a prior authorization exception to the requirements of this section. The division may exempt a prescriber from the need to secure prior authorization for a specific drug category if the division determines that the prescriber has written a minimum number of scripts in that category, and the prescriber prescribes prescription drugs on the preferred drug list at or above the minimum threshold for that category.

(f) If the patient is denied authorization of coverage, the denial shall be subject to an administrative fair hearing and to all rights under section 14 of chapter 30A of the General Laws.

(g) The division shall, using bulletins, manuals, notices or other appropriate means, educate prescribers and pharmacists who treat MassHealth patients about the requirements of the prior authorization process, including the obligations of providers and pharmacists and the rights of consumers.

Section 12B. Supplemental Rebates.

(a) The commissioner, separately or in concert with the authorized representatives of any health benefit plan participating in the prescription drug fair pricing program established by chapter 118H, shall use the division's preferred drug list of prescription drugs covered without a prior authorization requirement to negotiate with pharmaceutical companies for the payment to the commissioner of supplemental rebates or price discounts for Medicaid. The commissioner may also use the preferred drug list to negotiate for the payment of rebates or price discounts in connection with drugs covered under any other health benefit plan within or outside this state participating in the prescription drug fair pricing program established by chapter 118H. Such negotiations and any subsequent agreement shall comply with the provisions of 42 U.S.C. section 1396r-8. The program established by chapter 118H, or such portions of the program as the commissioner shall designate, shall constitute a state pharmaceutical assistance program under 42 U.S.C. section 1396r-8(c)(1)(C). The provisions of this section do not authorize agreements with pharmaceutical manufacturers whereby financial support for medical services covered by the Medicaid program is accepted as consideration for placement of one or more prescription drugs on the preferred drug list or for excluding a drug from any prior authorization requirement.

(b) The commissioner shall provide quarterly reports on the progress of negotiating supplemental rebates pursuant to this section to the joint committee on health care and the house and senate committees on ways and means. By September 1, 2003, the commissioner shall provide with the next occurring quarterly report a cost benefit analysis of alternative negotiation strategies, including strategies used by the state Medicaid agencies in states of Florida and Michigan to secure supplemental rebates and any other alternative negotiation strategy that might secure lower net prescription drug costs.

(c) The commissioner shall prohibit the public disclosure of information revealing company-identifiable trade secrets obtained by the department, and by any officer, employee or contractor of the department in the course of negotiations conducted pursuant to this section. Such confidential information shall be exempt from public disclosure.

Section 12C. Discount Program Waiver.

(a) The division shall seek a prescription drug discount program waiver from the Centers for Medicare and Medicaid Services pursuant to section 1115(a) of the Social Security Act. The prescription drug discount program shall provide eligible individuals with a financial subsidy for prescription drugs equal to the average rebate paid to the Medicaid program by pharmaceutical manufacturers. Eligible individuals shall include Medicare-eligible individuals whose financial eligibility exceeds 188 per cent of federal poverty level and who do not have an insurance policy that covers drugs and other individuals whose financial eligibility does not exceed 300 per cent of the federal poverty level who do not have an insurance program that includes a prescription drug benefit.

(b) The division may establish, as part of the discount program, an annual enrollment fee. Subject to appropriation, the division shall make a payment of at least 2 percent of the cost of each prescription or refill dispensed to individuals enrolled in the program.

(c) In implementing the program, the division may contract with a nonprofit corporation or other entity to administer the program. Such corporation or entity shall agree to assist individuals enrolled in the program to access other free or discount prescription drug programs offered by private entities, including pharmaceutical manufacturers.

(d) The division shall report to the house and senate committees on ways and means and the joint committee on health care, not later than 60 days after the effective date of this section, on the division's progress in implementing this section and shall report every 90 days thereafter on its progress in obtaining the waiver to those committees.

SECTION 2. The General Laws are hereby amended by inserting the following new chapter:

CHAPTER 118H.
The Massachusetts Prescription Drug Fair Pricing Program.

Section 1. Program Established.

(a) There is hereby established a program to reduce the cost to the Commonwealth of providing prescription drugs to its citizens while maintaining high quality in prescription drug therapies. The program shall include, but shall not be limited to, the following components:

(1) the development and use of a statewide, uniform preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic and therapeutic equivalents;

(2) the creation of a single purchasing unit for the purchase of prescription drugs by the commonwealth;

(3) the use of strategies to negotiate with pharmaceutical manufacturers to lower the cost of prescription drugs for program participants, including a supplemental rebate program;

(4) the development of educational programs, including a counterdetailing program, designed to provide information and education on the therapeutic and cost-effective utilization of prescription drugs to consumers, physicians, pharmacists and other health care professionals authorized to prescribe and dispense prescription drugs;

(5) the utilization of any available cost containment tools that meet program objectives by reducing the cost to the commonwealth of obtaining and providing prescription drugs, including clinical management tools, utilization review procedures, a prior authorization review process, duplicate prescription monitoring, and refill and supply controls;

(6) the observance of consumer protection rules to maintain high quality in prescription drug therapies and to protect access to needed prescriptions; and

(7) the operation of a discount program to provide the benefit of negotiated price discounts to uninsured citizens.

(b) The following state agencies shall participate in the program authorized in this chapter, to the extent permitted by federal law:

(1) the division of medical assistance;
(2) the executive office of elder affairs;
(3) the group insurance commission;
(4) the department of public health;
(5) the department of mental health;
(6) the department of mental retardation;
(7) the department of correction; and
(8) the division of employment and training.

(c) Any other public or private health benefit plan that purchases prescription drugs may elect to participate in all or portions of the program.

Section 2. Bulk Purchasing Agreements.

(a) State agencies and other participants in the program shall act as a single purchasing unit for the negotiation of a contract to purchase prescription drugs on behalf of the commonwealth.

(b) The prescription drug procurement unit created by section 62 of chapter 177 of the Acts of 2001 shall implement all or part of the program to the extent permitted by federal law. The secretary of the executive office of elder affairs, the commissioner of the group insurance commission and the commissioners of the departments of public health, mental health and mental retardation may renegotiate or amend existing contracts for the purchase of prescription drugs, including a contract made in conformance with said section 62, if such renegotiation or amendment is necessary to implement all or part of the program and will be of economic benefit to the health benefit plans subject to such contracts, and to the beneficiaries of such plans. Any renegotiated or substituted contract shall be designed to improve the overall quality of integrated health care services provided to beneficiaries of such plans.

Section 3. Pharmaceutical Benefits Manager.

(a) State agencies and other participants in the program may contract with a third party pharmacy benefit manager to assist in implementation of the program. Such pharmacy benefit manager shall be a non-profit corporation with expertise in the management of pharmacy benefits.

(b) No contract shall be signed with a pharmacy benefit manager unless the pharmacy benefit manager has agreed to disclose to the commonwealth, in a manner that preserves the confidentiality of any proprietary information:

(1) operating statements of the pharmacy benefit manager;

(2) total revenue attributable to pharmaceutical manufacturer rebates and total revenue not attributable to pharmaceutical manufacturer rebates;

(3) all sources of rebate revenue and non-rebate revenue, and amounts of revenue from such sources;

(4) rebate management fees collected;

(5) the terms and conditions of any contract with any subcontractor, including contracts with the pharmacy benefit manager's pharmacy network; and

(6) the terms and conditions of any sale or exchange of prescription drug data concerning beneficiaries or the prescribing practices of the providers.

(c) No contract shall be signed with a pharmacy benefit manager that has entered into an agreement or engaged in one or more of the following practices unless a majority of state agency participants in the program determines, after consideration of all relevant circumstances, that such agreement or practice furthers the financial interests of the commonwealth, and does not adversely affect the financial or medical interests of beneficiaries:

(1) any agreement with a pharmaceutical manufacturer to favor the manufacturer's products over a competitor's products, or to switch the drug prescribed by the patient's health care provider with a drug agreed to by the pharmacy benefit manager and the manufacturer;

(2) any agreement with a pharmaceutical manufacturer to share manufacturer rebates and discounts with the pharmacy benefit manager, or to pay soft money, so-called, or other economic benefits to the pharmacy benefit manager;

(3) any agreement to share revenue with a mail order or internet pharmacy company;

(4) any agreement or practice to bill the commonwealth's health benefit plans for prescription drugs at a cost higher than the pharmacy benefit manager pays the pharmacy; or

(5) any agreement to sell prescription drug data concerning beneficiaries, or data concerning the prescribing practices of health care providers.

Section 4. Cost Containment Tools.

(a) The program shall include the following components:

(1) A preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic alternatives.

(i) The preferred drug list shall be implemented as a uniform, statewide, preferred drug list for use by state agencies participating in the program and health benefit plans in the Commonwealth shall be encouraged to participate in the program.

(ii) The program may utilize the MassHealth Drug List developed by the division of medical assistance as its preferred drug list. In order to assist the state agencies participating in the program with the development, modification and timely revision of the preferred drug list, such agencies shall appoint a Drug List Review Board. The board may be comprised in whole or in part of representatives of state agencies, including the Drug Use Board established by the division of medical assistance pursuant to federal law, or may be established by contract with a public or private non-profit organization. The board shall:

(A) make recommendations for the adoption and maintenance of the preferred drug list based upon considerations of clinical efficacy, safety, and cost-effectiveness;

(B) meet at least quarterly;

(C) to the extent feasible, review all drug classes included in the preferred drug list at least every 12 months, and recommend additions to or deletions from the preferred drug list;.

(D) establish board procedures for the timely review of prescription drugs newly approved by the federal Food and Drug Administration, including procedures for the review of newly approved prescription drugs in emergency circumstances, including early refill review standards, a prior authorization review process, duplicate prescription monitoring, and quality and supply controls;

(E) encourage health benefit plans to implement the preferred drug list as a uniform, statewide preferred drug list by inviting the representatives of each health benefit plan providing prescription drug coverage to residents of the commonwealth to participate as observers or nonvoting members in the commissioners drug utilization review board, and by inviting such plans to use the preferred drug list in connection with the plans' prescription drug coverage.

(iii) Members of the board shall receive per diem compensation and reimbursement of board related expenses. The board shall consult with a preferred drug list advisory group which shall include 1 designee of the commissioner of mental health; 1 designee of the commissioner of public health; 1 designee of the secretary of the executive office of elder affairs; 1 physician with experience treating MassHealth patients; 1 practicing pediatrician with experience treating MassHealth patients; 1 practicing pharmacist with experience serving MassHealth patients; 1 pharmacologist with expertise in psychiatric drugs; 1 representative of a senior citizens advocacy group; 1 representative of a disability advocacy group; and 1 representative of a statewide advocacy group representing the interests of MassHealth members.

(2) A series of educational programs including a counterdetailing program, designed to provide information and education on the therapeutic and cost effective utilization of prescription drugs to consumers, physicians, pharmacists and other health care professionals authorized to prescribe and dispense prescription drugs.

(3) Consideration of alternative pricing mechanisms including consideration of using maximum allowable cost pricing for generic and other prescription drugs.

(4) Consideration of alternative coverage terms, including consideration of providing coverage of over-the-counter drugs where cost-effective in comparison to prescription drugs, and authorizing coverage of dosages capable of permitting the consumer to split each pill if cost-effective and medically appropriate for the consumer.

(5) Development of a simple, uniform prescription form, designed to implement the preferred drug list, and to enable prescribers and consumers to request an exception to the preferred drug list choice with a minimum of cost and time to prescribers, pharmacists and consumers.

Section 5. Consumer Protection Rules.

(a) The program shall authorize pharmacy benefit coverage when a patient's health care provider prescribes a prescription drug not on the preferred drug list, if a patient's health care provider certifies that:

(i) the drug is medically necessary; and

(ii) in the case of a prescription drug that is not the preferred choice in a therapeutic category on the preferred drug list,

(A) the preferred choice has not been effective, or with reasonable certainty is not expected to be effective in treating the patient's condition; or

(B) the preferred choice causes or is reasonably expected to cause adverse or harmful reactions in the patient.

(b) The prescriber's certification concerning whether a particular drug has been ineffective, is expected to be ineffective in treating the patient, or is expected to cause an adverse or harmful reaction shall be final.

(c) The program shall authorize coverage notwithstanding any prior authorization requirement if the patient agrees to pay any additional cost in excess of the benefits provided by the patient's health benefit plan. The provisions of this paragraph shall not apply in circumstances in which their application is inconsistent with federal Medicaid laws and regulations. The provisions of this paragraph shall not affect implementation by a participating health benefit plan of tiered co-payments or other similar cost sharing systems.

(d) The program or any participating health benefit plan shall provide information on how prescribers, pharmacists, beneficiaries, and other interested parties can obtain a copy of the preferred drug list, whether any change has been made to the preferred drug list since it was last issued, and the process by which exceptions to the preferred list may be made.

(e)(1) The program's prior authorization process shall be designed to minimize administrative burdens on prescribers, pharmacists, and consumers.

(2) The prior authorization process shall ensure real-time receipt of requests, by telephone, voice mail, facsimile, electronic transmission, or mail on a 24-hour basis, seven days a week.

(3) The prior authorization process shall provide an in-person response to emergency requests by a prescriber with telephone answering queues that do not exceed 10 minutes.

(4) Any request for authorization or approval of a drug that the prescriber indicates, including the clinical reasons for the request, is for an emergency or urgent condition shall be responded to in no more than 4 hours from the time the program or participating health benefit plan receives the request.

(5) In emergency circumstances, or if the response to a request for prior authorization is not provided within the time period established in subdivision (4) of this subsection, a 72-hour supply of the drug prescribed shall be deemed to be authorized by the program or the participating health benefit plan, provided it is a prescription drug approved by the United States Food and Drug Administration, and provided, for drugs dispensed to a Medicaid beneficiary, it is subject to a rebate agreement with the Centers for Medicare and Medicaid Services.

(6) The program or participating plan shall provide to participating providers a prior authorization request form designed to permit the prescriber to make prior authorization requests in advance of the need to fill the prescription, and designed to be completed without unnecessary delay. The form shall be capable of being stamped with information relating to the participating provider and, if feasible, at least one form capable of being copied shall contain known patient information.

(f) The program's prior authorization process shall require that the prescriber, not the pharmacy, request a prior authorization exception to the requirements of this section. The program may exempt a prescriber from the need to secure prior authorization for a specific drug category if the program determines that the prescriber has written a minimum number of scripts in that category, and the prescriber prescribes prescription drugs on the preferred drug list at or above the minimum threshold for that category.

(g) If the patient is denied authorization of coverage, the denial shall be subject to an administrative fair hearing and to all rights under section 14 of chapter 30A of the general laws.

Section 6. Discount Card Program.

(a) The commissioner of health and human services or another commissioner of a participating state agency designated by program participants shall implement a pharmacy discount plan, to be known as the Healthy Massachusetts Discount Card Plan, for residents without adequate coverage for prescription drugs. As used in this section, a resident without adequate coverage means a resident of the commonwealth with no insurance coverage for prescription drugs or with coverage for which the annual maximum coverage limit under his health benefit plan has been reached. Such plan shall establish a system through which residents

without adequate coverage are able to take advantage of discounted prices for prescription drugs negotiated pursuant to this chapter. Such commissioner shall implement the pharmacy discount program authorized by this section without any financial contribution by the state, and may establish an enrollment fee in such amount as is necessary to support the administrative costs of the plan. The plan shall be designed to work cooperatively with other state prescription drug assistance programs, including any program created pursuant to a discount program waiver granted by the Centers for Medicare and Medicaid Services to the division of medical assistance. Such commissioner may contract with a nonprofit corporation or other entity to administer the program. Such corporation or entity shall agree to assist individuals eligible for the program to access other free or discount prescription drug programs offered by private entities, including pharmaceutical manufacturers.

Section 7. Reporting and Legislative Oversight.

(a) The commissioner of health and human services or another commissioner of a participating state agency designated by program participants shall report quarterly to the joint committee on health care and the house and senate committees on ways and means on progress of the program in implementing a single state purchasing unit for prescription drugs pursuant to section 2. The report shall provide a status report on the formation of or operation of the contract negotiated pursuant to section 2, and shall identify any barriers to full implementation of section 2 and recommend any changes to the program or other legislative changes advisable to eliminate such barriers. The report shall also report on the program's progress in securing the participation of other health benefit plans with the commonwealth by means of joint purchasing agreements to enhance the commonwealth's purchasing power.

(b) Each year for the duration of the pharmacy benefit manager contract pursuant to section 3, the commissioner of health and human services or another commissioner of a participating state agency designated by program participants shall provide a status report on the contract and the operations of the pharmacy benefit manager to the joint committee on health care and the house and senate committees on ways and means. The report shall include:

(1) a description of the activities of the pharmacy benefit manager;

(2) an analysis of the success of the pharmacy benefit manager in achieving each of the department's public policy goals, together with the pharmacy benefit manager's report of its activities and achievements;

(3) an assessment, based upon information learned in contracting with the pharmacy benefits manager, of administrative costs relating to prescription drug benefits in the Medicaid program and the Prescription Advantage program established pursuant to section 39 of chapter 19A, including any recommendations for increasing the administrative efficiency of such programs;

(4) any recommendations for enhancing the benefits of or minimizing inefficiencies of the pharmacy benefit manager contract or advancing the commonwealth's public policy goals relating to pharmaceutical costs, quality and access;

(5) a fiscal report on the costs and savings to the commonwealth of the pharmacy benefit manager contract, including the information disclosed pursuant to paragraph (b) of section 3, in a manner that preserves the confidentiality of any proprietary information; and

(6) if the pharmacy benefit manager engages in any of the activities described in paragraph (c) of section 3, an explanation of the reasons for finding that such agreement or practice furthers the financial interests of the commonwealth, and does not adversely affect the financial or medical interests of beneficiaries.

(c) The commissioner of health and human services or another commissioner of a participating state agency designated by program participants shall report quarterly to the joint committee on health care and the house and senate committees on ways and means concerning the cost containment aspects of the program undertaken pursuant to section 4. Such report shall include:

(1) a copy of the preferred drug list, an explanation of the list, a summary of the operation of the prior authorization process or any other cost savings measures instituted as a part of the list, and an estimate of expected cost savings as a result of the preferred drug list;

(2) a description of the efforts undertaken to educate consumers and health care providers about the preferred drug list and the program's utilization review procedures;

(3) a description of the efforts undertaken to establish programs to educate health care providers about the costs of prescribing patterns, including counterdetailing programs;

(4) a report of other cost containment strategies undertaken, including, but not limited to, alternative pricing mechanisms and alternative coverage terms, the expected savings from such strategies, and the effect of such strategies on access to prescription drugs for consumers; and

(5) a status report on the development of a uniform prescription form and any barriers to such development.

(d) The joint committee on health care shall closely monitor implementation of the program, including the preferred drug list and utilization review procedures, to ensure that the consumer protection standards are not diminished as a result of implementing the preferred drug list and the utilization review procedures, including any unnecessary delay in access to appropriate medications. Such joint committee shall, by means of an oversight hearing or otherwise, ensure that all affected interests, including consumers, health care providers, pharmacists and others with pharmaceutical expertise have an opportunity to comment on the operation of the program, the preferred drug list, and other procedural aspects of the program.

SECTION 3. The General Laws are hereby amended by adding after chapter 268B the following chapter.—

CHAPTER 268C.
Physician and Pharmaceutical Manufacturer Conduct.

Section 1. As used in this chapter, the following words shall have the following meanings:—

"Gift", a payment, entertainment, subscription, advance, services or anything of value, unless consideration of equal or greater value is received. "Gift" shall not include a commercially reasonable loan made in the ordinary course of business, anything of value received by inheritance, a gift received from a member of the reporting person's immediate family or from a relative within the third degree of consanguinity of the reporting person or of the reporting person's spouse or from the spouse of any such relative,

or prescription drugs provided to a physician solely and exclusively for use by the physician's patients.

"Immediate family", a spouse and any dependent children residing in the reporting person's household.

"Medical device", an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is:

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

(2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or

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

"Person", a business, individual, corporation, union, association, firm, partnership, committee, or other organization or group of persons.

"Pharmaceutical marketer", a person who, while employed by or under contract to represent a pharmaceutical manufacturing company, engages in pharmaceutical detailing, promotional activities, or other marketing of prescription drugs in this state to any physician, hospital, nursing home, pharmacist, health benefit plan administrator, or any other person authorized to prescribe, dispense, or purchase prescription drugs. The term does not include a wholesale drug distributor licensed under section 36A, a representative of such a distributor who promotes or otherwise markets the services of the wholesale drug distributor in connection with a prescription drug, or a retail pharmacist registered under section 37 if such person is not engaging in such practices under contract with a manufacturing company.

"Pharmaceutical manufacturing company", any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drugs, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a

combination of extraction and chemical synthesis, or any entity engaged in the packaging, repackaging, labeling, relabeling, or distribution of prescription drugs. The term does not include a wholesale drug distributor licensed under section 36A or a retail pharmacist registered under section 37.

"Pharmaceutical manufacturer agent", a pharmaceutical marketer or any other person who for compensation or reward does any act to promote, oppose or influence the prescribing of a particular prescription drug or medical device or category of prescription drugs or medical devices. The term shall not include a licensed pharmacist, licensed physician or any other licensed health care professional with authority to prescribe prescription drugs who is acting within the ordinary scope of the practice for which he is licensed.

"Physician", a person licensed to practice medicine by the board of medicine pursuant to section 2 of chapter 112.

"Prescription drugs", any and all drugs upon which the manufacturer or distributor has placed or must, in compliance with federal law and regulations, place the following or a comparable warning: "Caution federal law prohibits dispensing without prescription."

Section 2. No pharmaceutical manufacturer agent shall knowingly and willfully offer or give to a physician or a member of a physician's immediate family, and no physician shall knowingly and willfully solicit or accept from any pharmaceutical manufacturer, gifts of any value at any time.

Section 3. A person who violates this section shall be punished by a fine of not more than $5,000 or by imprisonment for not more than 2 years, or both.

SECTION 4. The commissioner of the division of medical assistance, the secretary of the executive office of elder affairs, the commissioner of the group insurance commission and the commissioners of state agencies participating in the Massachusetts prescription drug fair pricing program established by chapter 118H of the general laws shall take all steps necessary to enable the commonwealth to participate in joint prescription drug purchasing agreements with other states and other health benefit plans. Such steps shall include:

(1) Active collaboration with the National Legislative Association on Prescription Drug Prices in the Association's efforts;

(2) Active collaboration with the Pharmacy RFP Issuing States Initiative, so-called, organized by the West Virginia Public Employees Insurance Agency; and

(3) The execution of any joint purchasing agreements or other contracts with any health benefit plan or organization within or outside the state which such commissioners determines will lower the cost of prescription drugs for the commonwealth and its citizens while maintaining high quality in prescription drug therapies.

SECTION 5. (a) The General Court finds that the National Legislative Association on Prescription Drug Prices is a nonprofit organization of legislators formed for the purpose of making prescription drugs more affordable and accessible to citizens of the member states, including the commonwealth. The General Court further finds that the activities of the Association provide a public benefit to the people of the commonwealth.

(b) Three members of the senate, including one member of the minority party, shall be appointed directors of the Association by the senate president, and three members of the house of representatives, including one member of the minority party, shall be appointed directors of the Association by the speaker of the house. Directors so appointed shall serve until new members are appointed.

(c) The directors of the Association shall report to the house and senate committees on ways and means and the joint committees on health care and insurance on or before January 1 of each year with a summary of the activities of the Association, and any findings and recommendations for making prescription drugs more affordable and accessible to citizens of the commonwealth.