Massachusetts Taxpayers Foundation

Bill Order	Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?	vs. 2022 PACT Act	Effective Date
1	1	6D	1	Adds definitions to "Biosimilar" and "Brand Name Drug" to HPC statute	N/A	No	Same	
2	2	6D	1	Adds definition of "Early notice" to HPC statute	N/A	No	Same	
3	3	6D	1	Adds definition of "Generic drug" to HPC statute	N/A	No	Same	
4	4	6D	1	Amends definition of "Payer" in HPC statute to include self-insured plans to the extent allowed by the Federal Employee Retirement Income Security Act of 1974. Current language excludes ERISA plans.	N/A	No	Same	
5	5	6D	1	Adds definitions of "Pharmaceutical manufacturing company" and "pharmacy benefit manager" to HPC statute	N/A	No	Same	
6	6	6D	1	Adds definition of "Pipeline drugs" to HPC statute	N/A	No	Same	
7	7	6D	1	Adds definition of "Wholesale acquisition cost" to the HPC statute	N/A	No	Same	
8	8	6D	2A	Adds references to proposed pharmaceutical/drug price responsibilities to the HPC section keeping information confidential and not subject to public records.	N/A	No	Same	
9	9	6D	4	Adds representatives of PBMs to the HPC advisory council	N/A	No	Same	
10	10-12	6D	6	Requires pharmaceutical companies, biopharma manufacturers and PBMs to pay 25% of the annual HPC appropriation (less for certain expenses). The HPC shall determine the manner and distribution of assessment. PBMs who already pay an assessment as a payor are exempt.	N/A	No	Updated	
11	13	6D	8	Adds PBM and pharmaceutical manufacturing costs, process, and cost trends to the scope of HPC cost trend hearings.	N/A	No	Same	
12	14	6D	8	Adds PBM and pharmaceutical manufacturer representatives to the list of witnesses for the hearing.	N/A	No	Same	
13	15	6D	8	Requires at least 3 representatives of the pharmaceutical manufacturing industry and 1 PBM to be included as witnesses for the hearing.	N/A	No	Same	
14	16	6D	8	Removes "and" from current two item list of topics to be addressed by providers and payers at the meeting.	N/A	No	Same	
15	17	6D	8	Adds a pharmaceutical manufacturer/PBM specific set of requirements to testimony provided at the hearing.	N/A	No	Updated	
16	18	6D	8	Adds information provided by pharmaceutical manufacturers/PBMs to the list of information used to compile the annual cost trends report. States that, to the extent feasible, the report shall not contain data likely to compromise the financial, competitive, or proprietary nature of the information.	N/A	Yes* (marginal admin costs)	Same	
17	19	6D	9	Adds pharmaceutical manufacturing/PBM information to the list of things examined at the HPC hearing to modify the state's health cost growth benchmark.	N/A	No	Same	
18	20	6D	15A	• Requires pharmaceutical manufacturing companies to provide early notice to the HPC for pipeline drugs, generic drugs, or biosimilar drugs. • HPC to provide info available to EOHHS, GIC, and DOI • Information regarding whether or not the drug has been ID'd as an orphan drug, for fast track, as a breakthrough therapy, or for a priority review • Early notice must be submitted to the HPC no later than 30 days of FDA action date • Generic early notice must include a copy of the drug label approved by the FDA • Early notice is also required if it plans to increase wholesale acquisition cost of a brand-name drug by more than 15 percent in a 12 month period or a generic drug or biosilimar with a significant price increase as determined by the HPC • Notification of price increase must occur not less than 30 days before increase and include drug sales volume info, wholesale price, net price and related info, drug acquisition info, revenue from the drug and manufacturer costs • HPC to conduct an annual study of PMCs subject to requirements of prior sections • If a pharmaceutical manufacturing company does not comply with requirements under this section, the commission can impose a penalty (as a last resort) of up to $500K for each instance of non-compliance • Penalties assessed will be deposited into the Prescription Drug Cost Assistance Trust Fund	N/A	Yes	Updated	

Bill Order	Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?	vs. 2022 PACT Act	Effective Date
19	21	6D	21	• Empowers the HPC to review eligible drugs to assess impact on patient access • Eligible drugs are: brand name drugs or biologics with a WAC of $50K or more for a 1 year supply; biosimilar drugs with a WAC that is not at least 15% lower than the brand biologic when the biosimilar is launched; a public health essential drug with a significant price increase (as determined by HPC) or with a WAC of $25K or more for one year; statutorily ID'd essential drugs (as proposed in the bill); or other drugs that may have a direct and significant impact and create affordability challenges as determined by the HPC (commission to develop regs governing this third category); • The HPC is empowered to require a manufacturer to disclose a variety of information related to price, including: schedule of WAC cost increases over 5 years; relevant R&D and capital expenditures; description of factors contributing to WAC increase over 5 years (absent proprietary info). • The HPC is tasked with using information to ID a proposed value for the drug (based on info from CHIA, the manufacturer, PBMs, and third parties) • The HPC cannot base price solely on analysis of an outside party. If they use a third party, they must disclose info on methodology and assumptions, including potential outcomes on subpopulations and racial and ethnic groups • The HPC cannot use a metric which assigns reduced value to a drug that extends life for a patient with an underlying condition • If the manufacture price is the same/less than proposed value, notify manufacturer and evaluate other ways to mitigate cost • If the price does exceed, manufacturer has 30 days for new information and the HPC can then require an Access Improvement Plan • The proposed value of a drug is not intended to be used to determine the need for a patient's prior authorization or utilization management criteria for a drug • The proposed value cannot be the sole source of info to determine whether or not a drug is included in a formulary or if the drug is subject to step therapy • If manufacturer does not provide request info, fine of up to $500K for each instance; fines are to be deposited into Prescription Drug Cost Assistance Trust Fund	Health Equity: Expanded Patient Access	Yes	Updated	
20	21	6D	22	• HPC can require a manuacturer provided with written notice under the prior section to file an access and affordability improvement plan • Manufacturers have 45 days to either file a plan or provide written notice declining to participate in the development of a plan • Manufacturers can submit an access and affordability improvement plan which includes specific strategies to address cost of the drug to improve access and affordability for both patients and the health system • The HPC can accept plan or ask for another one • Manufacturers to work to implement approved plans • The HPC will post on its website the manufacturers in the process of implementing a plan and remove the info from the website when the plan is successfully completed • At the conclusion of the plan, the manufacturer must report on the results of the access and affordability improvement plan • Fine of up to $500K for manufacturers not following the plan process in good faith, declining to participate, willfully neglecting to file a plan, failing to implement the plan in good faith, or knowingly not providing information required by the statute • If the manufacturer does not comply or declines to participate, HPC to publicly post price and require public testimony. The HPC shall submit recommendations to the legislature on how to improve the price. • If the HPC deems the manufacturer is not acting in good faith to develop or implement the plan, the HPC may publicly post the price and require public testimony. In this instance as well, the HPC will submit recommendations to Ways and Means and Health Care Financing • Prior to a determination that a manufacturer is not acting in good faith, the HPC shall notify the manufacturer and provide 30 days to address the issue	Health Equity: Expanded Patient Access	Yes	Updated	7/1/2024
21	21	6D	23	Requires HPC, in consultation with CHIA, Medicaid, GIC and DOI, to evaluate the impact of the essential drug identification process created in the bill every two years. The evaluation shall include: • Utilization rates of the drugs selected • Analysis of the use of drugs selected broken down by patient demographic, region and delivery device • Annual plan costs and member premiums • Information on drug price, both including and not including rebates, and out-of-pocket costs on delivery devices • Analysis of the impact of capping patient costs on access to care (by demographic group and geography) as well as an analysis of any barriers to accessing identified drugs	Health Equity: Expanded Patient Access	Yes	New	7/1/2024
22	22-25	12C	1	Adds following definitions to CHIA statute: • Average manufacturer price • Biosimilar • Brand name drug • Generic drug • Pharmaceutical manufacturing company • Pharmacy benefit manager (PBM • Wholesale acquisition cost (WAC)	N/A	No	Same	

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23	26	12C	3	Adds pharmaceutical manufacturers/PBMs to the list of organizations which CHIA is to collect, analyze and disseminate data.	N/A	No	Same	
24	27	12C	3	Adds pharmaceutical manufacturers/PBMs cost information to the list of things about which CHIA is to provide info at annual HPC cost trend hearings.	N/A	No	Same	
25	28	12C	5	Adds pharmaceutical manufacturers/PBMs to the list of organizations to be consulted on CHIA regulatory changes.	N/A	No	Same	
26	29	12C	5	Adds pharmaceutical manufacturers/PBMs to the list of organizations to be consulted on CHIA reporting requirements.	N/A	No	Same	
27	30-32	12C	7	Require pharmaceutical manufacturers/PBMs to pay 25 percent of the CHIA appropriation (less applicable costs). The CHIA is to determine the manner of the assessment. PBM's who pay as health insurers to be exempt.	N/A	No	Same	
28	33	12C	10A	Requires CHIA to collect and analyze drug pricing info, including • Year over year WAC and avg manufacturer price • YoY net expenditure trends • Net expenditures by subset of biosimilar, brand name and generic drug • Trends in estimated aggregate drug rebates (or similar programs) offered to a PBM, wholesaler, payer, distributor, pharmacy • Discounts provided direct to consumer • R&D costs as a share of revenue; annual marketing costs (including direct to consumer) • Profits over 5 years • Disparities with purchase cost outside of the US Requires CHIA to collect info from Pharmacy manufacturers including • Changes in WAC and average manufacturer prices for ID'd drugs • Aggregate company level R&D/capital costs attributable to a specific product • True net typical prices to PBMs by payor type • Annual marketing and advertising expenditures • Description of factors contributing to changes in WAC/average manufacturer price Requires CHIA to report on PBM information, including: • Trends in aggregated drug rebates and other price reductions provided to health plans or passed through to health plans • A measure of the lives covered by each plan served by PBMs • PBM practices as they relate to rebates and drug reductions • Other information deemed necessary Requires CHIA to collect info from PBMs including: • Amount of rebates received from manufacturers • True net typical prices to PBMs by payor type • Administrative fees • Amount of retained rebates • Detailed info on rebates where PBM retains $, passes through $ to the carrier or plan sponsor, and info on the division between the two • Percentage of contracts that a PBM holds where the PBM retains all rebates; passes through all rebates; shares rebates with clients • Information on practices related to spread pricing, administrative fees, claw backs and formulary placement	N/A	Yes	Updated	
29	34	12C	11	Includes pharmaceutical manufacturers & PBMs in the section requiring timely reporting on information due to CHIA. Also eliminates maximum penalty of $50K; imposes $2K fee per week for delayed submissions.	N/A	Yes	Same	
30	35	12C	12	Amends the section regarding how CHIA is to collect, store, and share data to include data collected from pharmaceutical manufacturers/PBMs.	N/A	No	Same	
31	36	12C	16	Adds information on pharmaceutical and PBM price trends and cost data to the scope of the CHIA annual report.	N/A	No	Same	
32	37	12C	16	Eliminates the requirement that CHIA cost reporting only considers the effect of drug rebates and price concessions in the aggregate.	N/A	No	Same	
33	38	12C	16	Requires CHIA's annual report to include information on prescription drug utilization and spending for drugs provided in outpatient settings or sold in retail settings. Info to include: • Highest utilization drugs • Drugs with greatest increase in utilization • Drugs most impactful to plan spending • Drugs with highest year over year price increases, net of rebates CHIA is prohibited from including any data likely to compromise the financial, competitive, or proprietary nature of the information in the report	N/A	No	Same	
34	39	17	13	Requires the Drug Formulary Commission to ID and publish a list of public health essential prescription drugs (and defines what those drugs are), to be updated annually. It requires the list to include drugs that apppear on the Model List of Essential Medicines and drugs and delivery devices staturtorily identified as essential, as proposed in the bill. The list is to be provided to the HPC	N/A	Yes	Updated	7/1/2024

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35	40	29	2BBBBBB	Creates a Prescription Drug Cost Assistance Fund. • Resources in the fund will be used to support the state's prescription drug cost assistance program (under MGL 111) • The fund will be capitalized by appropriations and gifts • The fund is not subject to appropriation • EOHHS will submit an annual report on uses from the fund	N/A	No	Updated	
36	41	32A	17T	Directs the GIC to identify one generic and one name brand drug each for three separate chronic conditions. Drugs selected shall not be subject to cost-sharing (including copayments and coinsurance) and shall not be subject to a deductible. The copayment for brand name drugs selected shall not exceed $25 for a 30 day supply. The list shall be updated annually and 90 day notice shall be provided to the HPC of any changes and 30 day notice will be provided to members The applicable chronic conditions are: • Diabetes • Asthma • Heart conditions, including conditions with disproportionate impact on communities of color or other particular demographic groups Drugs selected: • Must include insulin • Must include a drug that is among the top three most prescribed (or highest volume) for the chronic condition The selection must also consider: • A drug's proven benefit and likelihood to reduce hospitalization, future illnesss, or improve quality of life • Cost (compared to cost of the condition worsening) • Risk for abuse • Financial impact on individuals • Health equity If a selected drug requires a delivery device, a delivery device must also be selected in consideration of the same factors. Individuals (with their prescribing physician) may reqest different drugs of the same pharmacological class if certain criteria are met, including likelihood of ineffectiveness and contraindication of the brand name or generic drug. Requires the GIC to provide 90 day continuity of coverage for new GIC members with prior prescriptions (without cost sharing requirements higher than for other drugs covered by GIC) This section shall apply as far as is permissable under IRS code as it relates to health savings accounts.	Health Equity: Marginalized Communities & Expanded Patient Access	Yes	New	7/1/2025
37	42	111	245	Directs DPH to establish and administer a Drug Cost Assistance Program, supported by the Drug Cost Assistance Trust Fund. The program: • Provides financial assistance for prescription drugs used to treat chronic conditions, including respiratory and heart conditions (including heart conditions that impact people of color or specific demographic groups), diabetes, chronic conditions that disproportionately affect people of color, and risk factors for COVID 19 • The program is open to MA residents with a prescription for a chronic condition, have a family income of 500% FPL or less and is not on MassHealth • DPH to create an application process, with applications to be processed within 10 days • Eligible applicants shall have a program ID card valid for 12 months which can be presented at any pharmacy in the state • The individual shall receive the prescription without co-pay, coinsurance or deductible and will be reimbursed by the fund • DPH, in conjunction with DOI and the Board of Registration in Pharmacy will develop an education plan • The department shall develop an education plan on the program and compile an annual report on the program in collaboration with the DOI, Board of Pharmacy and stakeholders. The report will be submitted to Ways and Means and Health Care Financing	Health Equity: Marginalized Communities	Yes	New	
38	43	112	39K	Creates a new section in MGL 112 creating a process for the licensing of specialty pharmacies. • Specialty pharmacies dispense specialty medications • Each pharmacy to designate a manager of record responsible for disclosing required information to the Board • Board of registration of pharmacy and DOI to develop regs to implement the section and establish standards for the handling, safety and monitoring of specialty drugs	N/A	Yes	Updated	4/1/2024

Bill Order	Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?	vs. 2022 PACT Act	Effective Date
39	44	118E	10R	Directs the MassHealth to identify and provide coverage for one generic and one name brand drug each for three separate chronic conditions. Drugs selected shall not be subject to cost-sharing (including copayments and coinsurance) and shall not be subject to a deductible. The copayment for brand name drugs selected shall not exceed $25 for a 30 day supply. The list shall be updated annually and 90 day notice shall be provided to the HPC of any changes and 30 day notice will be provided to members The applicable chronic conditions are: • Diabetes • Asthma • Heart conditions, including conditions with disproportionate impact on communities of color or other particular demographic groups Drugs selected: • Must include insulin • Must include a drug that is among the top three most prescribed (or highest volume) for the chronic condition The selection must also consider: • A drug's proven benefit and likelihood to reduce hospitalization, future illnesss, or improve quality of life • Cost (compared to cost of the condition worsening) • Risk for abuse • Financial impact on individuals • Health equity If a selected drug requires a delivery device, a delivery device must also be selected in consideration of the same factors. Individuals (with their prescribing physician) may reqest different drugs of the same pharmacological class if certain criteria are met, including likelihood of ineffectiveness and contraindication of the brand name or generic drug. Requires the MassHealth to provide 90 day continuity of coverage for new members with prior prescriptions (without cost sharing requirements higher than for other drugs covered by MassHealth) This section does not apply to Senior Care Options health plans This section shall apply as far as is permissable under IRS code as it relates to health savings accounts.	Enhancement of Subsidized Benefit & Health Equity	Yes	New	7/1/2025
40	45	175	47UU	Adds language to MGL 175:47N (insurance) requiring carriers governed by this chapter to identify and provide coverage for one generic and one name brand drug each for three separate chronic conditions. Drugs selected shall not be subject to cost-sharing (including copayments and coinsurance) and shall not be subject to a deductible. The copayment for brand name drugs selected shall not exceed $25 for a 30 day supply. The list shall be updated annually and 90 day notice shall be provided to the HPC of any changes and 30 day notice will be provided to members The applicable chronic conditions are: • Diabetes • Asthma • Heart conditions, including conditions with disproportionate impact on communities of color or other particular demographic groups Drugs selected: • Must include insulin • Must include a drug that is among the top three most prescribed (or highest volume) for the chronic condition The selection must also consider: • A drug's proven benefit and likelihood to reduce hospitalization, future illnesss, or improve quality of life • Cost (compared to cost of the condition worsening) • Risk for abuse • Financial impact on individuals • Health equity If a selected drug requires a delivery device, a delivery device must also be selected in consideration of the same factors. Individuals (with their prescribing physician) may reqest different drugs of the same pharmacological class if certain criteria are met, including likelihood of ineffectiveness and contraindication of the brand name or generic drug. Requires the carrier to provide 90 day continuity of coverage for new members with prior prescriptions (without cost sharing requirements higher than for other drugs covered by carrier) This section shall apply as far as is permissable under IRS code as it relates to health savings accounts.	Health Equity: Marginalized Communities & Expanded Patient Access	No	New	7/1/2025

Bill Order	Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?	vs. 2022 PACT Act	Effective Date
41	46	175	226	Repeals section 226 which requires PBMs to conduct audits of its records with the pharmacies with whom they work.	N/A	No	Same	
42	47	176A	8VV	Adds language to MGL 176A (Non-profit hospital service corporations) requiring carriers governed by this chapter to identify and provide coverage for one generic and one name brand drug each for three separate chronic conditions. Drugs selected shall not be subject to cost-sharing (including copayments and coinsurance) and shall not be subject to a deductible. The copayment for brand name drugs selected shall not exceed $25 for a 30 day supply. The list shall be updated annually and 90 day notice shall be provided to the HPC of any changes and 30 day notice will be provided to members The applicable chronic conditions are: • Diabetes • Asthma • Heart conditions, including conditions with disproportionate impact on communities of color or other particular demographic groups Drugs selected: • Must include insulin • Must include a drug that is among the top three most prescribed (or highest volume) for the chronic condition The selection must also consider: • A drug's proven benefit and likelihood to reduce hospitalization, future illnesss, or improve quality of life • Cost (compared to cost of the condition worsening) • Risk for abuse • Financial impact on individuals • Health equity If a selected drug requires a delivery device, a delivery device must also be selected in consideration of the same factors. Individuals (with their prescribing physician) may reqest different drugs of the same pharmacological class if certain criteria are met, including likelihood of ineffectiveness and contraindication of the brand name or generic drug. Requires the carrier to provide 90 day continuity of coverage for new members with prior prescriptions (without cost sharing requirements higher than for other drugs covered by carrier) This section shall apply as far as is permissable under IRS code as it relates to health savings accounts.	Health Equity: Marginalized Communities & Expanded Patient Access	No	New	7/1/2025

Bill Order	Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?	vs. 2022 PACT Act	Effective Date
43	48	176B	4VV	Adds language to MGL 176B (Medical service corporations) requiring carriers governed by this chapter to identify and provide coverage for one generic and one name brand drug each for three separate chronic conditions. Drugs selected shall not be subject to cost-sharing (including copayments and coinsurance) and shall not be subject to a deductible. The copayment for brand name drugs selected shall not exceed $25 for a 30 day supply. The list shall be updated annually and 90 day notice shall be provided to the HPC of any changes and 30 day notice will be provided to members The applicable chronic conditions are: • Diabetes • Asthma • Heart conditions, including conditions with disproportionate impact on communities of color or other particular demographic groups Drugs selected: • Must include insulin • Must include a drug that is among the top three most prescribed (or highest volume) for the chronic condition The selection must also consider: • A drug's proven benefit and likelihood to reduce hospitalization, future illnesss, or improve quality of life • Cost (compared to cost of the condition worsening) • Risk for abuse • Financial impact on individuals • Health equity If a selected drug requires a delivery device, a delivery device must also be selected in consideration of the same factors. Individuals (with their prescribing physician) may reqest different drugs of the same pharmacological class if certain criteria are met, including likelihood of ineffectiveness and contraindication of the brand name or generic drug. Requires the carrier to provide 90 day continuity of coverage for new members with prior prescriptions (without cost sharing requirements higher than for other drugs covered by carrier) This section shall apply as far as is permissable under IRS code as it relates to health savings accounts.	Health Equity: Marginalized Communities & Expanded Patient Access	No	New	7/1/2025
44	49	176D	3B	Requires carriers to allow any network speciality pharmacy licensed under MGL 112:39K to dispense specialty drugs included in the carriers drug plan provided that the specialty pharmacy agrees to the in-network reimbursement rate for the drug	N/A	No	Updated	
45	50	176D	3B	Requires carriers to allow any network pharmacy to provide mail delivery services to the insured, provided that the specialty pharmacy agrees to the in-network reimbursement rate for the drug	N/A	No	Updated	
46	51	176D	3B	Defines "specialty drugs" for the purposes of the section	N/A	No	Updated	

Bill Order	Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?	vs. 2022 PACT Act	Effective Date
47	52	176G	4NN	Adds language to MGL 176G (Health maintenance organizations) requiring carriers governed by this chapter to identify and provide coverage for one generic and one name brand drug each for three separate chronic conditions. Drugs selected shall not be subject to cost-sharing (including copayments and coinsurance) and shall not be subject to a deductible. The copayment for brand name drugs selected shall not exceed $25 for a 30 day supply. The list shall be updated annually and 90 day notice shall be provided to the HPC of any changes and 30 day notice will be provided to members The applicable chronic conditions are: • Diabetes • Asthma • Heart conditions, including conditions with disproportionate impact on communities of color or other particular demographic groups Drugs selected: • Must include insulin • Must include a drug that is among the top three most prescribed (or highest volume) for the chronic condition The selection must also consider: • A drug's proven benefit and likelihood to reduce hospitalization, future illnesss, or improve quality of life • Cost (compared to cost of the condition worsening) • Risk for abuse • Financial impact on individuals • Health equity If a selected drug requires a delivery device, a delivery device must also be selected in consideration of the same factors. Individuals (with their prescribing physician) may reqest different drugs of the same pharmacological class if certain criteria are met, including likelihood of ineffectiveness and contraindication of the brand name or generic drug. Requires the carrier to provide 90 day continuity of coverage for new members with prior prescriptions (without cost sharing requirements higher than for other drugs covered by carrier) This section shall apply as far as is permissable under IRS code as it relates to health savings accounts.	Health Equity: Marginalized Communities & Expanded Patient Access	No	New	7/1/2025
48	53	176O	2	Requires health insurance carriers that contract with PBMs to "coordinate" an audit of the operations of PBMs in compliance with MGL 1760 (health insurance consumer protections) every 3 years.	N/A	No	Same	
49	54	176O	22A (NEW)	Require health insurance carriers to require that any PBM with whom they contract be licensed under the (proposed) MGL 176Y	N/A	No	Same	7/1/2024
50	55	176O	30 (NEW)	Prohibits carriers or entities working on their behalf from imposing cost sharing for a covered prescription which would exceed the negotiated price or usual customary charge, whichever is lower. Contracts with pharmacies cannot impose penalties on pharmacists for complying with this section.	N/A	No	Same	
51	56	176Y (New)	1	Defines the following terms related to the licensing and regulation of PBMs: • Carrier • Center (CHIA) • Commissioner (DOI) • Division (DOI) • Health Plan • Pharmacy • PBM	N/A	No	Updated	3/30/2024
52	56	176Y (New)	2	Prohibits a PBM from operating without receiving a license from DOI. Allows DOI to grant licenses of three years to PBMs that demonstrate organization, expertise and financial integrity to supply the relevant services. Further defines the licensure process: • Prohibits transfer of PBM licenses • Requires PBMs to comply with CHIA data collection requirements • Empowers DOI to suspend, revoke or refuse a license for cause or to put restrictions on licenses • Requires DOI to develop a PBM licensure application • Requires PBMs to submit to periodic carrier audits • Penalties for violations of the PBM licensure process will be deposited in the Prescription Drug Cost Assistance Trust Fund	N/A	Yes	Same	3/30/2024

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53	56	176Y (New)	3	Defines the process for examinations of PBMs: • Commissioner of DOI to examine PBMs at least once every 3 years • Reports on examinations to file report on examination within 60 days • PBM has 30 days to respond or rebut any aspects of the examination • DOI can order the PBM to take action to address any identified violations • PBM can accept report, can demand a reopening of the examination, or call for an investigatory hearing • Records of audits are confidential, though can be shared with other state and federal agencies (provided they keep the information confidential) • The final report of any audit will be a public record	N/A	No	Same	3/30/2024
54	57	NWS		Requires the Health Connector, in consultation with DOI, to report on the impact of pharmaceutical pricing on health care costs and outcomes for those receiving insurance through the Connector, with $500K provided for the cost of the study. The information provided would not be a public record. The report will consider: • The impact on the difference between list price and price net of rebates on premium costs • The impact of drug price changes over time on premium and out of pocket costs • Trends in change in drug price and rebate by health plan	N/A	Yes	Same	
55	58	NWS		Creates a 14 member commission to examine the feasibility of establishing a bulk purchasing process for the purchase and distribution of pharmaceuticals and making bulk purchasing info available to purchasers in other states.	N/A	No	Updated	
56	59	NWS		Creates a 10 member task force to review the drug supply chain. Task force considerations will include: • Administrative prices charged to pharmacies • Unique challenges of independent pharmacies • Utilization of maximum allowable cost lists • Comparison of pharmacy acquisition cost from national/regional wholesalers compared to reimbursement amount provided through a maximum allowable cost list or similar structures • Review the process by which an independent pharmacist request an adjustment on reimbursement subject to a maximum allowable cost list	N/A	No	Updated	
57	60	NWS		Directs the HPC to consult with relevant stakeholders in the development and periodic review of the impact of drug price on patient access as related to MGL 6D:21. The section specifically cites the requirement for consultation related to the development of the proposed value of an eligible drug and the appropriate price increase for a public health essential drug.	N/A	No	Same	
58	61	NWS		Requires each carrier to report annually to DOI the drugs selected to have limited cost sharing pursuant to this bill. DOI shall review the drugs with HPC and CHIA to verify that they meet the criteria established for the drug cost program. If a drug does not meet the critera, DOI can require another drug to be selected. DOI will publish the list of drugs selected on its website.	N/A	Yes	New	7/1/2025
59	62	NWS		Requires the HPC to establish a threshold for a significant price increase for a generic drug (as required by MGL 6D:15A in the bill) as a drug with a WAC of $100 or more whose cost increases by 100 percent or more over a twelve month period. This requirement sunsets on 1/1/2025.	N/A	No	Same	
60	63	Effective Date		Repeals section 62	N/A		Same	1/1/2025
61	64	NWS		Requirs the HPC, in consultation with DPH, MassHealth, GIC and DOI to study insurance specialty pharmacy networks in the state. The report will describe drugs most often provided by specialty pharmacies, the impact of existing networks on access, cost, and care, and make recommendations for increasing patient access and meeting cost goals.	N/A	No	New	
62	65	NWS		Requires regulations for licensure of specialty pharmacies to be completed by 12/31/2023	N/A	No	New	
63	66	Effective Date		Makes sections 21 and 39 effective 7/1/24	N/A	No	Same	
64	67	Effective Date		Makes chronic condition cost cap program (sections 41, 44, 45, 47, 48, 52 and 61) effective 7/1/2025	N/A	No	New	
65	68	Effective Date		Makes speciality pharmacy licensure section (43) effective 4/1/2024	N/A	No	New	
66	69	Effective Date		Makes section PBM audit section (54) effective 7/1/24	N/A	No	Same	