Massachusetts Taxpayers Foundation

Bill Order	Bill Section	MGL Chapter	MGL Section	Session Citation	Bill Section Summary	Category	State Fiscal Impact?
1	1 & 2	6D	1		Adds or amends the following definitions in HPC's statute: • Payer (amended) • Pharmaceutical manufacturing company (PMC - new) • Pharmacy benefit manager (PBM - new)		
2	3	6D	3		Creates a new Office for Pharmaceutical Policy within the HPC. The Office shall • Analyze drug spending and other information collected by the HPC and other agencies, produce reports, ID proposed supplemental rebates for eligible drugs, and advise the legislature. • Analyses shall include an annual survey of payers on drug access, plan design, and member costs. • The Office will produce an annual report (due 9/1) on drug trends as they relate to costs, drugs with the highest impact on costs, patient drug spend, and access & affordability for patients with rare and chronic diseases or drugs designated as "first in class". • The office is directed to consult with the Rare Disease Advisory Council on drugs related to rare diseases or designated as "first in class"(due on 9/1) by the FDA. • In working with the Commission to ID proposed supplemental rebates, the Office will consider effectiveness, patient quality of life, and likely impact on need for future medical care.		
3	4	6D	4		Adds PBMs and PMCs to the list of perspectives to be represented on the HPC's Advisory Council.		
4	5	6D	6		Changes the HPC assessment mechanism for hospitals and adds new assessments for PMCs and PBMs. Under the new system: • The assessment for hospitals, ambulatory surgical centers and non-hospital provider organizations will be between 30 and 40 percent of the HPC appropriation (less fees and federal reimbursements). Non-hospital provider organizations will pay between 3 and 8 percent of the amount • Provider payments will be proportional to gross patient service revenue • PMCs will pay between 5 and 10 percent of the HPC appropriation (less fees and federal revenues) and will be based on its share of MassHealth net spending for the PMC's drugs • PBMs will pay between 5 and 10 percent of the HPC appropriation (net of fees and federal revenues). PBM payments shall be based on the aggregate revenue of the PBM attributable to MA as a share of all PBM revenue in the state		
5	6 through 11	6D	8		Adds PMCs and PBMs to the scope of the HPC annual hearing held in October and subsequent report: • 2 PBM witnesses are added to the witness list • 3 PMC witnesses including one representing a generic drug company, one representing a publicly traded company, and one representing a company that has been in existence for less than 10 years • PBM and PMC testimony shall relate to factors related to cost, the impact of rebates • Testimony shall not compromise the fiscal, competitive or proprietary nature of info		
6	12 & 13	6D	9		Adds PMC and PBM data costs to the list of factors to be considered at the HPC cost benchmark hearing and adds PMCs and PBMs to the list of witnesses to be represented at the hearing.		
7	14	6D	22		Directs HPC, in conjunction with CHIA, GIC, and MassHealth to conduct an evaluation of the co-payment caps established in the bill. The evaluation will be conducted every two years and will consider impacts on premiums, drug spending, rebates, cost-sharing, utilization and health impacts.	Health Equity	
8	15 through 17	12C	1		Adds or amends the following definitions in CHIA's statute: • Payer (amended) • Pharmaceutical manufacturing company (PMC - new) • Pharmacy benefit manager (PBM - new) • Wholesale acquisition cost (New)		
9	18 & 19	12C	3		Adds PMCs and PBMs to the list of entities from which CHIA collects and analyzes data and assists with data collection and analysis in conjunction with the HPC.		

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10	20 & 21	12C	5		Directs CHIA to notify and consult with PMCs and PBMs (as it does with other HC entities from which it collects data) on relevant regulations and rules.		
11	22	12C	7		Changes the CHIA assessment mechanism for hospitals and adds new assessments for PMCs and PBMs. Under the new system: • The assessment for hospitals, ambulatory surgical centers and non-hospital provider organizations will be between 30 and 40 percent of the CHIA appropriation (less fees and federal reimbursements). Non-hospital provider organizations will pay between 3 and 8 percent of the amount • Provider payments will be proportional to gross patient service revenue • PMCs will pay between 5 and 10 percent of the CHIA appropriation (less fees and federal revenues) and will be based on its share of MassHealth net spending for the PMC's drugs • PBMs will pay between 5 and 10 percent of the CHIA appropriation (net of fees and federal revenues). PBM payments shall be based on the aggregate revenue of the PBM attributable to MA as a share of all PBM revenue in the state		
12	23	12C	10A (New)		Creates a new section directing CHIA to create a uniform data reporting system for PBMs. The new system will allow analysis of: • Year over year WAC changes • Year over year trends in formulary, max allowable cost lists and cost share design • Info on discounts, utilization limits, rebates, fees, etc. • Amounts paid from PBMs to pharmacies owned or controlled by the PBM • Data necessary for DOI oversight of PBMs		
13	23	12C	10B (New)		Creates a new section directing CHIA to develop an annual list of the 10 prescriptions it determines are provided at the most substantial cost to the commonwealth (considering net cost) and experienced a substantial net increase (a WAC net of rebates that grows by at least 25 percent over the prior year). The list will include drugs from different therapeutic classes at not more than 3 generics. • PMCs can submit data to CHIA prior to publication of the list (during a 30 day comment period) info that would affect analysis on cost and cost increases. CHIA has 15 days after the end of the comment period to remove a drug • PMCs included on the published list must provide CHIA with a narrative description of factors affecting cost, aggregate R&D and capital spending CHIA deems relevant • Data provided by PMCs must be consistent with quality and the type of info provided to the SEC or other public disclosures • CHIA shall work with PMCs to develop a standardized data reporting form • CHIA will publish an annual report based on the info received • Info provided under the section shall not be a public record and shall not be disclosed in a way that would compromise the PMC or allow for a 3rd party to ID an individual drug, prices charged for a particular drug or the value of a rebate for a drug.		
14	24	12C	11		Adds OMCs and PBMs to the list of entities CHIA may fine for failing to provide required information after due notice.		
15	25	12C	12		Adds new sections 10A and 10B to a reference of sections covered by CHIA requirements for the storage and maintenance of data.		
16	26	12C	16(a)		Adds PMCs and PBMs to the list of entities to be covered in CHIA's annual report.		

Bill Order	Bill Section	MGL Chapter	MGL Section	Session Citation	Bill Section Summary	Category	State Fiscal Impact?
17	27	32A	17S		Creates a co-pay capping program within CHIA. Under the program: • GIC is annually required to ID (and make public) one generic and one brand name drug used to treat diabetes (which must include insulin), asthma, and the heart condition most prevalent among its members • In ID'ing drugs, GIC is to consider factors including the benefit of the drug, likelihood to reduce future treatment, utilization, risk of over-utilization and cost effectiveness • ID'd generic drugs shall be provided without cost sharing requirements including co-pay and co-insurance. ID'd drugs shall not be subject to a deductible. • ID'd brand name drugs shall have co-pays capped at $25 for a 30 day supply and will also not be subject to a deductible or co-insurance • GIC shall provide continuity of coverage by providing a 30 day fill for new members on an FDA approved drug that the member has already been prescribed as part of a stable course of treatment. Continuity of coverage will not be subject to any greater deductible, co-insurance or copay than any other benefit.		
18	28	94C	21B		Requires pharmacies to charge individuals the lesser of the applicable cost sharing amount and the retail cost of the drug and prohibits insurers from requiring a cost-sharing payment for a drug that is greater than the lesser of the cost sharing amount or the retail price of the drug.		
19	29	118E	10Q		Creates a co-pay capping program within MassHealth. Under the program: • MassHealth is annually required to ID (and make public) one generic and one brand name drug used to treat diabetes (which must include insulin), asthma, and the heart condition most prevalent among its members • In ID'ing drugs, MassHealth is to consider factors including the benefit of the drug, likelihood to reduce future treatment, utilization, risk of over-utilization and cost effectiveness • ID'd generic drugs shall be provided without cost sharing requirements including co-pay and co-insurance. ID'd drugs shall not be subject to a deductible. • ID'd brand name drugs shall have co-pays capped at $25 for a 30 day supply and will also not be subject to a deductible or co-insurance • This cost capping policy does not apply to Senior Care Option plans. • MassHealth shall provide continuity of coverage by providing a 30 day fill for new members on an FDA approved drug that the member has already been prescribed as part of a stable course of treatment. Continuity of coverage will not be subject to any greater deductible, co-insurance or copay than any other benefit.		
20	30	175	47VV (New)		Creates a co-pay capping program for carriers subject to MGL 175. Under the program: • Affected insurers are annually required to ID (and make public) one generic and one brand name drug used to treat diabetes (which must include insulin), asthma, and the heart condition most prevalent among its members • In ID'ing drugs, insurers are to consider factors including the benefit of the drug, likelihood to reduce future treatment, utilization, risk of over-utilization and cost effectiveness • ID'd generic drugs shall be provided without cost sharing requirements including co-pay and co-insurance. ID'd drugs shall not be subject to a deductible. • ID'd brand name drugs shall have co-pay capped at $25 for a 30 day supply and will also not be subject to a deductible or co-insurance • Any policy qualifying as providing credible coverage shall provide continuity of coverage by providing a 30 day fill for new members on an FDA approved drug that the member has already been prescribed as part of a stable course of treatment. Continuity of coverage will not be subject to any greater deductible, co-insurance or copay than any other benefit.		
21	31	175	226		Repeals section requiring PBMs to conduct audits (as detailed in the section) of the pharmacies with whom it contracts.		

Bill Order	Bill Section	MGL Chapter	MGL Section	Session Citation	Bill Section Summary	Category	State Fiscal Impact?
22	32	176A	8WW (New)		Creates a co-pay capping program for carriers subject to MGL 176A. Under the program: • Affected insurers are annually required to ID (and make public) one generic and one brand name drug used to treat diabetes (which must include insulin), asthma, and the heart condition most prevalent among its members • In ID'ing drugs, insurers are to consider factors including the benefit of the drug, likelihood to reduce future treatment, utilization, risk of over-utilization and cost effectiveness • ID'd generic drugs shall be provided without cost sharing requirements including co-pay and co-insurance. ID'd drugs shall not be subject to a deductible. • ID'd brand name drugs shall have co-pay capped at $25 for a 30 day supply and will also not be subject to a deductible or co-insurance • Any affected health benefit shall provide continuity of coverage by providing a 30 day fill for new members on an FDA approved drug that the member has already been prescribed as part of a stable course of treatment. Continuity of coverage will not be subject to any greater deductible, co-insurance or copay than any other benefit.		
23	33	176B	4WW (New)		Creates a co-pay capping program for carriers subject to MGL 176B. Under the program: • Affected insurers are annually required to ID (and make public) one generic and one brand name drug used to treat diabetes (which must include insulin), asthma, and the heart condition most prevalent among its members • In ID'ing drugs, insurers are to consider factors including the benefit of the drug, likelihood to reduce future treatment, utilization, risk of over-utilization and cost effectiveness • ID'd generic drugs shall be provided without cost sharing requirements including co-pay and co-insurance. ID'd drugs shall not be subject to a deductible. • ID'd brand name drugs shall have co-pay capped at $25 for a 30 day supply and will also not be subject to a deductible or co-insurance • Any affected health benefit shall provide continuity of coverage by providing a 30 day fill for new members on an FDA approved drug that the member has already been prescribed as part of a stable course of treatment. Continuity of coverage will not be subject to any greater deductible, co-insurance or copay than any other benefit.		
24	34	176G	4OO		Creates a co-pay capping program for carriers subject to MGL 176B. Under the program: • Affected insurers are annually required to ID (and make public) one generic and one brand name drug used to treat diabetes (which must include insulin), asthma, and the heart condition most prevalent among its members • In ID'ing drugs, insurers are to consider factors including the benefit of the drug, likelihood to reduce future treatment, utilization, risk of over-utilization and cost effectiveness • ID'd generic drugs shall be provided without cost sharing requirements including co-pay and co-insurance. ID'd drugs shall not be subject to a deductible. • ID'd brand name drugs shall have co-pay capped at $25 for a 30 day supply and will also not be subject to a deductible or co-insurance • Any affected health benefit shall provide continuity of coverage by providing a 30 day fill for new members on an FDA approved drug that the member has already been prescribed as part of a stable course of treatment. Continuity of coverage will not be subject to any greater deductible, co-insurance or copay than any other benefit.		
25	35	176O	30		Requires insurers to annually report to DOI the drugs selected for the cost capping program created in the bill. DOI will review the drugs selected to insure that they comply with the requirements of the policy, if there is a lack of compliance, DOI can require the selection of another drug. DOI will publish the list of selected drugs annually on its website.		

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26	35	176O	31		Requires insurers and PBMs to provide to the insured at least 80 percent of the estimated rebate received for a drug in the form of reduced cost sharing (provided cost sharing does not go below $0). Insurers must report to DOI each year demonstrating compliance with this requirement. The section prohibits PBMs from publishing information on the actual amount of rebates a carrier receives. Such information is considered a trade secret and shall not be disclosed in any manner that would allow for ID of an individual product, class or manufacturer or could compromise the financial, competitive or proprietary nature of the information.		
27	36	176Y (New)	1		Creates a new MGL chapter regulating PBMs. Section 1 defines terms relevant to the chapter: • Carrier • Clean claim • Commissioner of insurance • Cost sharing • Division of Insurance • Health benefit plan • Independent pharmacy • Insured • Mail order pharmacy • Net price • Pharmacy • Pharmacy benefit management services • Pharmacy benefit manager • Pharmacy benefit manager network • Rebate • Spread pricing • Third party administrator		
28	36	176Y (New)	2		Requires all PBMs to be licensed by DOI. Under the section: • Licenses can be granted for 3 year periods • There is a $25K application fee • DOI is to develop an application • DOI has the power to (after written notice and providing an opportunity for a hearing) revoke, repeal, or place on probation a license in case of fraud, justified consumer complaint, failure to comply with the chapter or failure to submit required info to CHIA.		
29	36	176Y (New)	3		Establishes a standard of care, skill prudence, diligence, and professionalism for PBMs. The standard applies to both the insured and the health plan with whom the PBM is contracted.		
30	36	176Y (New)	4		PBMs must provide a reasonably adequate and accessible network for provision of drugs and provide insurers with convenient access to pharmacies within a reasonable distance. PBMs shall not deny a pharmacy the opportunity to participate in its network provided the pharmacy is willing to access the relevant terms and conditions Mail order pharmacies cannot be included in the calculation for determining PBM network adequacy.		

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31	36	176Y (New)	5		After approving a 'clean claim' for payment from a pharmacy, a PBM cannot retroactively reduce payment unless it is later determined that the claim is not clean or based on fraud. PBMs cannot charge cost sharing from an insured that exceeds the contracted amount the PBM paid the pharmacy.		
32	36	176Y (New)	6		Prohibits a drug from being placed on a maximum allowable cost list (MACL) unless it meets standards as generically or pharmaceutically equivalent (or has a similar, nationally recognized rating), is in stock and available, and is not obsolete PBMs must provide access to its MACL to all pharmacies in its network, update that list on a timely basis, provide notice of updates, create an internal grievance process for pharmacies. PBMs must respond to grievances within 30 days and, if the grievance is warranted, reprocess the claim and reimburse appropriately. If the grievance is not warranted, the PBM must provide relevant backup info to the pharmacy. Prohibits PBMs from reimbursing independent pharmacists less than they reimburse pharmacies with whom the PBM is affiliated. Violations of the section qualify as unfair or deceptive practices under MGL 93A.		
33	36	176Y (New)	7		Prohibits PBMs from engaging in spread pricing. PBMs in violation will be subject to the surcharge created in section 8. Requires PBMs to report quarterly to DOI all information required to be collected by CHIA under MGL 12C:10A		
34	36	176Y (New)	8		Establishes a surcharge of 10 percent of a PBMs payments to pharmacies (either directly or through its carrier) in the previous contract year. The Surcharge is to be paid if the PBM or carrier is found to engage in spread pricing or impose point of sale or retroactive fees. PBMs subject to the surcharge will be afforded an adjudicatory hearing under MGL 30A		
35	36	176Y (New)	9		Requires insurers to count payments made on behalf of an insured towards any applicable cost sharing requirement. If this section conflicts with Health Savings Account eligibility requirements set forth by the IRS, it sets forth how the requirement is to be applied. Prohibits carriers or PBMs from altering the terms of a health plan based in part or entirely on information about the availability or amount of financial assistance available for a drug.		
36	36	176Y (New)	10		Sets forth PBM audit requirements of pharmacies, previously included in MGL 175:226 in this chapter of law. The provisions are essentially identical to the previous MGL 175 language.		
37	36	176Y (New)	11		Establishes a process for DOI to examine the affairs of PBMs at least once every 3 years. The review shall include an on-site review of the PBM. Within 60 days of the examination, DOI will file a report on the PBM. The PBM has 30 days to provide a written rebuttal to any matters in the report. 30 days after submission or written response, DOI can adopt the report, order modifications and corrections, reject the report and require additional information, or call for an investigatory hearing of the PBM. If the report is adopted with modifications or corrections, DOI can order the PBM to take corrective action. Records examined as part of the process shall be confidential. DOI can grant access to information to law enforcement and other agencies, provided the receiving agency abides by confidentiality requirements.		
38	36	176Y (New)	12		Requires PBMs to submit to periodic audits by its carriers. DOI will develop rules governing this process.		

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39	36	176Y (New)	13		Prohibits PBM contracts with pharmacies from preventing the pharmacy from providing a person with relevant information about drug cost, cost-sharing and clinical efficacy of alternatives. Contracts cannot penalize pharmacies for providing such information. PBMs are prohibited from charging pharmacies a fee for adjudicating a claim unless the fee is set out in the contract. PBM contracts with pharmacies cannot prevent disclosure of information to the DOI.		
40	37			2012 Chapter 139	Eliminates the sunset on drug coupons.		
41	38	NWS	NWS		Directs the HPC Office of Pharmaceutical Policy and Analysis (with MassHealth) to report on the future of cell and gene therapy in the state. The analysis will examine ways to address barriers to access for MassHealth and vulnerable populations. The study will focus on therapies expected to come to market by 2035 and will include • A projection on the number of products expected to be available • An assessment of estimated cost of coverage • An assessment of how reimbursement processes will impact barriers to coverage that could disproportionately affect MassHealth and vulnerable populations • An assessment as to whether the current health care facility infrastructure is sufficient to meet demands for the delivery of these products in a way to ensure equitable access The report is due by 7/31/2025 and the HPC will consult with relevant stakeholders in its development.	Health Equity	
42	39	NWS	NWS		Makes the cost capping provisions of the bill effective for plans entered into, amended, extended or renewed on or after 8/1/2025.		
43	40	NWS	NWS		Directs CHIA to publish its initial high cost drug list by 3/31/2026.		
44	41	NWS	NWS		Makes section 35 (requirement of rebate value returned to insured) effective 4/1/2025		
45	42	NWS	NWS		Requires PBMs to be licensed not later than 1/1/2025		
46	43	NWS	NWS		Makes sections 7-9 of the new PBM statute effective on 8/1/2025.		