SENATE . . . . . No. 2492

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Third General Court
(2023-2024)

SENATE, October 30, 2023.

The committee on Health Care Financing, to whom was referred the petitions (accompanied by bill, Senate, No. 732) of John J. Cronin for legislation to promote comprehensive transparency in the pharmaceutical industry; (accompanied by bill, Senate, No. 749) of Cindy F. Friedman, Rebecca L. Rausch, Susannah M. Whipps, Joanne M. Comerford and other members of the General Court for legislation relative to pharmaceutical access, costs and transparency; (accompanied by bill, Senate, No. 767) of Jason M. Lewis for legislation to define modest meals and refreshments in prescriber education settings; (accompanied by bill, Senate, No. 778) of Paul W. Mark for legislation to bring down the cost of prescription drugs; (accompanied by bill, Senate, No. 783) of Mark C. Montigny and Michael J. Barrett for legislation to promote transparency and prevent price gouging of pharmaceutical drug prices; (accompanied by bill, Senate, No. 784) of Mark C. Montigny for legislation relative to coverage for chronic illness; (accompanied by bill, Senate, No. 797) of Jacob R. Oliveira for legislation to bring down the cost of prescription drugs; (accompanied by bill, House, No. 619) of Nicholas A. Boldyga relative to establishing a prescription drug rebate program for seniors; (accompanied by bill, House, No. 1176) of Edward F. Coppinger and others relative to promoting comprehensive transparency in the pharmaceutical industry; (accompanied by bill, House, No. 1201) of Kate Hogan relative to the pricing of prescription drugs; (accompanied by bill, House, No. 1205) of Bradley H. Jones, Jr., and others that the Health Policy Commission and health insurers create listings of certain high cost prescription drugs and that the Attorney General require drug manufacturers to provide information to justify increases in costs; (accompanied by bill, House, No. 1206) of Bradley H. Jones, Jr., and others for an investigation by a special commission (including members of the General Court) relative to contracts between the MassHealth program and pharmaceutical benefit managers; (accompanied by bill, House, No. 1215) of John J. Lawn, Jr., and others relative to pharmacy benefit managers; (accompanied by bill, House, No. 1246) of William M. Straus relative to drug prices paid by carriers; and (accompanied by bill, House, No. 1247) of Alyson M. Sullivan-Almeida, Michael J. Soter and David F. DeCoste relative to pharmacy benefit managers reimbursements to pharmacies in the Commonwealth, reports the accompanying bill (Senate, No. 2492).

For the committee,
Cindy F. Friedman

FILED ON: 10/27/2023

SENATE . . . . . No. 2492

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Third General Court
(2023-2024)

An Act relative to pharmaceutical access, costs and transparency.

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 6A of the General Laws is hereby amended by adding the following section:-

Section 16DD. (a) The following terms shall have the following meanings, unless the context clearly requires otherwise:

"Brand name drug", a drug that is: (i) produced or distributed pursuant to an original new drug application approved under 21 U.S.C. 355(c) except for: (a) any drug approved through an application submitted under section 505(b)(2) of the federal Food, Drug, and Cosmetic Act that is pharmaceutically equivalent, as that term is defined by the United States Food and Drug Administration, to a drug approved under 21 U.S.C. 355(c); (b) an abbreviated new drug application that was approved by the United States Secretary of Health and Human Services under section 505(c) of the federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(c), before the 2 of 53 date of the enactment of the federal Drug Price Competition and Patent Term Restoration Act of 1984, Public Law 98-417, 98 Stat. 1585; or (c) an authorized generic drug as defined by

42 C.F.R. 447.502; (ii) produced or distributed pursuant to a biologics license application approved under 42 U.S.C. 262(a)(2)(C); or (iii) identified by the health benefit plan as a brand name drug based on available data resources such as Medi-Span.

"Generic drug", a retail drug that is: (i) marketed or distributed pursuant to an abbreviated new drug application approved under 21 U.S.C. 355(j); (ii) an authorized generic drug as defined by 42 C.F.R. 447.502; (iii) a drug that entered the market before January 1, 1962 and was not originally marketed under a new drug application; or (iv) identified by the health benefit plan as a generic drug based on available data resources such as Medi-Span.

(b) Notwithstanding any general or special law to the contrary, there shall be a drug access program, administered by the executive office of health and human services, for the purpose of enhancing access to targeted high-value medications used to treat certain chronic conditions. To implement the drug access program, the secretary of health and human services, in consultation with the department of public health, the division of insurance, the health policy commission, and the center for health information and analysis, shall identify one generic drug and one brand name drug used to treat each of the following chronic conditions: (i) diabetes; (ii) asthma; and (iii) heart conditions, including, but not limited to, hypertension and coronary artery disease. In determining the one generic drug and one brand name drug used to treat each chronic condition, the secretary shall consider whether the drug is:

(1) of clear benefit and strongly supported by clinical evidence to be cost-effective;

(2) likely to reduce hospitalizations or emergency department visits, or reduce future exacerbations of illness progression, or improve quality of life;

(3) relatively low cost when compared to the cost of an acute illness or incident prevented or delayed by the use of the service, treatment or drug;

(4) at low risk for overutilization, abuse, addiction, diversion or fraud; and

(5) widely utilized as a treatment for the chronic condition.

(c) The secretary of health and human services shall identify insulin as the drug used to treat diabetes under the drug access program.

(d) Every two years, the secretary of health and human services, in consultation with the health policy commission, the center for health information and analysis and the division of insurance, shall evaluate the impact of the drug access program established in this section on drug treatment adherence, incidence of related acute events, premiums and cost-sharing, overall health, long-term health costs, and any other issues that the secretary may deem relevant. The secretary may collaborate with an independent research organization to conduct such evaluation. The secretary shall file a report of its findings with the clerks of the house of representatives and senate, the chairs of the joint committee on public health, the chairs of the joint committee on health care financing and the chairs of house and senate committees on ways and means.

(e) The secretary, in consultation with the division of insurance, shall promulgate rules and regulations necessary to implement this section.

SECTION 2. Section 1 of chapter 6D of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after the definition of “Alternative payment methodologies or methods” the following 2 definitions:-

"Biosimilar", a drug that is produced or distributed pursuant to a biologics license application approved under 42 U.S.C. 262(k)(3).

"Brand name drug", a drug that is: (i) produced or distributed pursuant to an original new drug application approved under 21 U.S.C. 355(c) except for: (a) any drug approved through an application submitted under section 505(b)(2) of the federal Food, Drug, and Cosmetic Act that is pharmaceutically equivalent, as that term is defined by the United States Food and Drug Administration, to a drug approved under 21 U.S.C. 355(c); (b) an abbreviated new drug application that was approved by the United States Secretary of Health and Human Services under section 505(c) of the federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(c), before the date of the enactment of the federal Drug Price Competition and Patent Term Restoration Act of 1984, Public Law 98-417, 98 Stat. 1585; or (c) an authorized generic drug as defined by 42 C.F.R. 447.502; (ii) produced or distributed pursuant to a biologics license application approved under 42 U.S.C. 262(a)(2)(C); or (iii) identified by the health benefit plan as a brand name drug based on available data resources such as Medi-Span.

SECTION 3. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Disproportionate share hospital" the following definition:-

"Early notice", advanced notification by a pharmaceutical manufacturing company of a: (i) new drug, device or other development coming to market; or (ii) a price increase, as described in subsection (b) of section 15A.

SECTION 4. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Fiscal year" the following definition:-

"Generic drug", a retail drug that is: (i) marketed or distributed pursuant to an abbreviated new drug application approved under 21 U.S.C. 355(j); (ii) an authorized generic drug as defined by 42 C.F.R. 447.502; (iii) a drug that entered the market before January 1, 1962 and was not originally marketed under a new drug application; or (iv) identified by the health benefit plan as a generic drug based on available data resources such as Medi-Span.

SECTION 5. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 189, the words "not include excludes ERISA plans" and inserting in place thereof the following words:- include self-insured plans to the extent allowed under the federal Employee Retirement Income Security Act of 1974.

SECTION 6. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Performance penalty" the following 2 definitions:-

"Pharmaceutical manufacturing company", an entity engaged in the: (i) production, preparation, propagation, compounding, conversion or processing of prescription drugs, directly or indirectly, by extraction from substances of natural origin, independently by means of chemical synthesis or by a combination of extraction and chemical synthesis; or (ii) packaging, repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that "pharmaceutical manufacturing company" shall not include a wholesale drug distributor licensed under section 36B of chapter 112 or a retail pharmacist registered under section 39 of said chapter 112.

"Pharmacy benefit manager", a person, business or other entity, however organized, that directly or through a subsidiary provides pharmacy benefit management services for prescription drugs and devices on behalf of a health benefit plan sponsor, including, but not limited to, a self-

insurance plan, labor union or other third-party payer; provided, however, that pharmacy benefit management services shall include, but not be limited to: (i) the processing and payment of claims for prescription drugs; (ii) the performance of drug utilization review; (iii) the processing of drug prior authorization requests; (iv) pharmacy contracting; (v) the adjudication of appeals or grievances related to prescription drug coverage contracts; (vi) formulary administration; (vii) drug benefit design; (viii) mail and specialty drug pharmacy services; (ix) cost containment; (x) clinical, safety and adherence programs for pharmacy services; and (xi) managing the cost of covered prescription drugs; provided further, that "pharmacy benefit manager" shall include a health benefit plan that does not contract with a pharmacy benefit manager and manages its own prescription drug benefits unless specifically exempted by the commission.

SECTION 7. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Physician" the following definition:-

"Pipeline drug", a prescription drug product containing a new molecular entity for which the sponsor has submitted a new drug application or biologics license application and received an action date from the United States Food and Drug Administration.

SECTION 8. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by adding the following definition:-

"Wholesale acquisition cost", shall have the same meaning as defined in 42 U.S.C. 1395w-3a(c)(6)(B).

SECTION 9. Said chapter 6D is hereby further amended by striking out section 2A, as so appearing, and inserting in place thereof the following section:-

Section 2A. The commission shall keep confidential all nonpublic clinical, financial, strategic or operational documents or information provided or reported to the commission in connection with any care delivery, quality improvement process, performance improvement plan, early notification or access and affordability improvement plan activities authorized under sections 7, 10, 14, 15, 15A, 20 or 21 of this chapter or under section 2GGGG of chapter 29 and shall not disclose the information or documents to any person without the consent of the payer, provider or pharmaceutical manufacturing company providing or reporting the information or documents under said sections 7, 10, 14, 15, 15A, 20 or 21 of this chapter or under said section 2GGGG of said chapter 29, except in summary form in evaluative reports of such activities or when the commission believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anticompetitive considerations. The confidential information and documents shall not be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66.

SECTION 10. Section 4 of said chapter 6D, as so appearing, is hereby amended by striking out, in lines 7 and 8, the word “manufacturers” and inserting in place thereof the following words:- manufacturing companies, pharmacy benefit managers,.

SECTION 11. Section 6 of said chapter 6D, as so appearing, is hereby amended by inserting after the word “center”, in line 1, the following words:- , pharmaceutical and biopharmaceutical manufacturing company, pharmacy benefit manager.

SECTION 12. Said section 6 of said chapter 6D, as so appearing, is hereby further amended by striking out, in lines 5 and 36, the figure “33” and inserting in place thereof, in each instance, the following figure:- 25.

SECTION 13. Said section 6 of said chapter 6D, as so appearing, is hereby further amended by adding the following paragraph:-

The assessed amount for pharmaceutical and biopharmaceutical manufacturing companies and pharmacy benefit managers shall be not less than 25 per cent of the amount appropriated by the general court for the expenses of the commission minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the commission's publication or dissemination of reports and information; and (iii) federal matching revenues received for these expenses or received retroactively for expenses of predecessor agencies. Pharmaceutical and biopharmaceutical manufacturing companies and pharmacy benefit managers shall, in a manner and distribution determined by the commission, pay to the commonwealth an amount of the estimated expenses of the commission attributable to the commission’s activities under sections 8, 9, 15A, 20 and 21. A pharmacy benefit manager that is a surcharge payor subject to the preceding paragraph and manages its own prescription drug benefits shall not be subject to additional assessment under this paragraph

SECTION 14. Section 8 of said chapter 6D, as so appearing, is hereby amended by inserting after the word “organization”, in lines 6 and 7, the following words:- , pharmacy benefit manager, pharmaceutical manufacturing company.

SECTION 15. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word “organizations”, in line 14, the following words:- , pharmacy benefit managers, pharmaceutical manufacturing companies.

SECTION 16. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 32, the words “and (xi)” and inserting in place thereof the

following words:- (xi) not less than 3 representatives of the pharmaceutical industry; (xii) at least 1 representative of the pharmacy benefit management industry; and (xiii).

SECTION 17. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 48, the first time it appears, the word “and”.

SECTION 18. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word “commission”, in line 59, the first time it appears, the following words:- ; and (iii) in the case of pharmacy benefit managers and pharmaceutical manufacturing companies, testimony concerning factors underlying prescription drug costs and price increases including, but not limited to, the initial prices of drugs coming to market and subsequent price increases, changes in industry profit levels, marketing expenses, reverse payment patent settlements, the impact of manufacturer rebates, discounts and other price concessions on net pricing, the availability of alternative drugs or treatments and any other matters as determined by the commission.

SECTION 19. Subsection (g) of said section 8 of said chapter 6D, as so appearing, is hereby amended by striking out the second sentence and inserting in place thereof the following 2 sentences:-

The report shall be based on the commission’s analysis of information provided at the hearings by witnesses, providers, provider organizations, payers, pharmaceutical manufacturing companies and pharmacy benefit managers, registration data collected under section 11, data collected or analyzed by the center under sections 8, 9, 10 and 10A of chapter 12C and any other available information that the commission considers necessary to fulfill its duties under this section as defined in regulations promulgated by the commission. To the extent practicable, the

report shall not contain any data that is likely to compromise the financial, competitive or proprietary nature of the information.

SECTION 20. Section 9 of said chapter 6D, as so appearing, is hereby amended by inserting after the word “organization”, in line 72, the following words:- , pharmacy benefit manager, pharmaceutical manufacturing company.

SECTION 21. Said chapter 6D is hereby further amended by inserting after section 15 the following section:-

Section 15A. (a) A pharmaceutical manufacturing company shall provide early notice to the commission in a manner described in this section for a: (i) pipeline drug; (ii) generic drug; or (iii) biosimilar drug. The commission shall provide non-confidential information received under this section to the office of Medicaid, the division of insurance and the group insurance commission.

Early notice under this subsection shall be submitted to the commission in writing not later than 30 days after receipt of the United States Food and Drug Administration approval date.

For each pipeline drug, early notice shall include a brief description of the: (i) primary disease, health condition or therapeutic area being studied and the indication; (ii) route of administration being studied; (iii) clinical trial comparators; and (iv) estimated date of market entry. To the extent possible, information shall be collected using data fields consistent with those used by the federal National Institutes of Health for clinical trials.

For each pipeline drug, early notice shall include whether the drug has been designated by the United States Food and Drug Administration: (i) as an orphan drug; (ii) for fast track; (iii)

as a breakthrough therapy; (iv) for accelerated approval; or (v) for priority review for a new molecular entity; provided, however, that notwithstanding clause (v), submissions for drugs in development that are designated as new molecular entities by the United States Food and Drug Administration shall be provided as soon as practical upon receipt of the relevant designations. For each generic drug, early notice shall include a copy of the drug label approved by the United States Food and Drug Administration.

(b) A pharmaceutical manufacturing company shall provide early notice to the commission if it plans to increase the wholesale acquisition cost of a: (i) brand-name drug by more than 15 per cent per wholesale acquisition cost unit during any 12-month period; or (ii) generic drug with a significant price increase as determined by the commission during any 12-month period. The commission shall provide non-confidential information received under this section to the office of Medicaid, the division of insurance and the group insurance commission.

Early notice under this subsection shall be submitted to the commission in writing not less than 60 days before the planned effective date of the increase.

A pharmaceutical manufacturing company required to notify the commission of a price increase under this subsection shall, not less than 30 days before the planned effective date of the increase, report to the commission any information regarding the price increase that is relevant to the commission including, but not limited to: (i) drug identification information; (ii) drug sales volume information; (iii) wholesale price and related information for the drug; (iv) net price and related information for the drug; (v) drug acquisition information, if applicable; (vi) revenue from the sale of the drug; and (vii) manufacturer costs.

(c) The commission shall conduct an annual study of pharmaceutical manufacturing companies subject to the requirements in subsections (a) and (b). The commission may contract with a third-party entity to implement this section.

(d) Notwithstanding any general or special law to the contrary, information provided under this section shall be protected as confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66.

(e) If a pharmaceutical manufacturing company fails to timely comply with the requirements under subsection (a) or subsection (b), or otherwise knowingly obstructs the commission's ability to receive early notice under this section, including, but not limited to, providing incomplete, false or misleading information, the commission may impose appropriate sanctions against the manufacturer, including reasonable monetary penalties not to exceed $500,000, in each instance. The commission shall seek to promote compliance with this section and shall only impose a civil penalty on the manufacturer as a last resort. Amounts collected under this section shall be deposited into the Prescription Drug Cost Assistance Trust Fund established in section 2RRRRR of chapter 29.

SECTION 22. Said chapter 6D is hereby further amended by adding the following 2 sections:-

Section 20. (a) As used in this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Eligible drug", (i) a brand name drug or biologic, not including a biosimilar, that has a launch wholesale acquisition cost of $50,000 or more for a 1-year supply or full course of treatment; (ii) a biosimilar drug that has a launch wholesale acquisition cost that is not at least 15

per cent lower than the referenced brand biologic at the time the biosimilar is launched; (iii) a public health essential drug, as defined in subsection (f) of section 13 of chapter 17, with a significant price increase over a defined period of time as determined by the commission by regulation or with a wholesale acquisition cost of $25,000 or more for a 1-year supply or full course of treatment; or (iv) other prescription drug products that may have a direct and significant impact and create affordability challenges for the state's health care system and patients, as determined by the commission; provided, however, that the commission shall promulgate regulations to establish the type of prescription drug products classified under clause (iv) prior to classification of any such prescription drug product under said clause (iv).

"Manufacturer", a pharmaceutical manufacturer of an eligible drug.

"Public health essential drug", shall have the same meaning as defined in subsection (f) of section 13 of chapter 17.

(b) The commission shall review the impact of eligible drug costs on patient access; provided, however, that the commission may prioritize the review of eligible drugs based on potential impact to consumers.

In order to conduct a review of eligible drugs, the commission may require a manufacturer to disclose to the commission within a reasonable time period information relating to the manufacturer's pricing of an eligible drug. The disclosed information shall be on a standard reporting form developed by the commission with the input of the manufacturers and shall include, but not be limited to:

(i) a schedule of the drug's wholesale acquisition cost increases over the previous 5 calendar years;

(ii) the manufacturer's aggregate, company-level research and development and other relevant capital expenditures, including facility construction, for the most recent year for which final audited data are available;

(iii) a narrative description, absent proprietary information and written in plain language, of factors that contributed to reported changes in wholesale acquisition cost during the previous 5 calendar years; and

(iv) any other information that the manufacturer wishes to provide to the commission or that the commission requests.

(c) Based on the records furnished under subsection (b) and available information from the center for health information and analysis or an outside third party, the commission shall identify a proposed value for the eligible drug. The commission may request additional relevant information that it deems necessary.

Any information, analyses or reports regarding an eligible drug review shall be provided to the manufacturer. The commission shall consider any clarifications or data provided by the manufacturer with respect to the eligible drug. The commission shall not base its determination on the proposed value of the eligible drug solely on the analysis or research of an outside third party and shall not employ a measure or metric that assigns a reduced value to the life extension provided by a treatment based on a pre-existing disability or chronic health condition of the individuals whom the treatment would benefit. If the commission relies upon a third party to provide cost-effectiveness analysis or research related to the proposed value of the eligible drug, such analysis or research shall also include, but not be limited to: (i) a description of the methodologies and models used in its analysis; (ii) any assumptions and potential limitations of

research findings in the context of the results; and (iii) outcomes for affected subpopulations that utilize the drug, including, but not limited to, potential impacts on individuals of marginalized racial or ethnic groups, and on individuals with specific disabilities or health conditions who regularly utilize the eligible drug.

(d) If, after review of an eligible drug and after receiving information from the manufacturer under subsection (b) or subsection (e), the commission determines that the manufacturer's pricing of the eligible drug does not substantially exceed the proposed value of the drug, the commission shall notify the manufacturer, in writing, of its determination and shall evaluate other ways to mitigate the eligible drug's cost in order to improve patient access to the eligible drug. The commission may engage with the manufacturer and other relevant stakeholders, including, but not limited to, patients, patient advocacy organizations, consumer advocacy organizations, providers, provider organizations and payers, to explore options for mitigating the cost of the eligible drug. Upon the conclusion of a stakeholder engagement process under this subsection, the commission shall issue recommendations on ways to reduce the cost of the eligible drug for the purpose of improving patient access to the eligible drug. Recommendations may include, but shall not be limited to: (i) an alternative payment plan or methodology; (ii) a bulk purchasing program; (iii) co-pay, deductible, coinsurance or other cost-sharing restrictions; and (iv) a reinsurance program to subsidize the cost of the eligible drug. The recommendations shall be publicly posted on the commission's website and provided to the clerks of the house of representatives and senate, the joint committee on health care financing and the house and senate committees on ways and means.

(e) If, after review of an eligible drug, the commission determines that the manufacturer's pricing of the eligible drug substantially exceeds the proposed value of the drug, the commission

shall request that the manufacturer provide further information related to the pricing of the eligible drug and the manufacturer's reasons for the pricing not later than 30 days after receiving the request.

(f) Not later than 60 days after receiving information from the manufacturer under subsection (b) or subsection (e), the commission shall confidentially issue a determination on whether the manufacturer's pricing of an eligible drug substantially exceeds the commission's proposed value of the drug. If the commission determines that the manufacturer's pricing of an eligible drug substantially exceeds the proposed value of the drug, the commission shall confidentially notify the manufacturer, in writing, of its determination and request the manufacturer to enter into an access and affordability improvement plan under section 21.

(g) Records disclosed by a manufacturer under this section shall: (i) be accompanied by an attestation that all information provided is true and correct; (ii) not be public records under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66; and (iii) remain confidential; provided, however, that the commission may produce reports summarizing any findings; provided further, that any such report shall not be in a form that identifies specific prices charged for or rebate amounts associated with drugs by a manufacturer or in a manner that is likely to compromise the financial, competitive or proprietary nature of the information.

Any request for further information made by the commission under subsection (e) or any determination issued or written notification made by the commission under subsection (f) shall not be public records under said clause Twenty-sixth of said section 7 of said chapter 4 or under said chapter 66.

(h) The commission's proposed value of an eligible and the commission's underlying analysis of the eligible drug is not intended to be used to determine whether any individual patient meets prior authorization or utilization management criteria for the eligible drug. The proposed value and underlying analysis shall not be the sole factor in determining whether a drug is included in a formulary or whether the drug is subject to step therapy.

(i) If the manufacturer fails to timely comply with the commission's request for records under subsection (b) or subsection (e), or otherwise knowingly obstructs the commission's ability to issue its determination under subsection (f), including, but not limited to, by providing incomplete, false or misleading information, the commission may impose appropriate sanctions against the manufacturer, including reasonable monetary penalties not to exceed $500,000, in each instance. The commission shall seek to promote compliance with this section and shall only impose a civil penalty on the manufacturer as a last resort. Penalties collected under this subsection shall be deposited into the Prescription Drug Cost Assistance Trust Fund established in section 2RRRRR of chapter 29.

(j) The commission shall adopt any written policies, procedures or regulations that the commission determines are necessary to implement this section.

Section 21. (a) The commission shall establish procedures to assist manufacturers in filing and implementing an access and affordability improvement plan.

Upon providing written notice provided under subsection (f) of section 20, the commission shall request that a manufacturer whose pricing of an eligible drug substantially exceeds the commission's proposed value of the drug file an access and affordability improvement plan with the commission. Not later than 45 days after receipt of a notice under

said subsection (f) of said section 20, a manufacturer shall: (i) file an access and affordability improvement plan; or (ii) provide written notice declining the commission's request.

(b) An access and affordability improvement plan shall: (i) be generated by the manufacturer; (ii) identify the reasons for the manufacturer's drug price; and (iii) include, but not be limited to, specific strategies, adjustments and action steps the manufacturer proposes to implement to address the cost of the eligible drug in order to improve the accessibility and affordability of the eligible drug for patients and the state's health system. The proposed access and affordability improvement plan shall include specific identifiable and measurable expected outcomes and a timetable for implementation. The timetable for an access and affordability improvement plan shall not exceed 18 months.

(c) The commission shall approve any access and affordability improvement plan that it determines: (i) is reasonably likely to address the cost of an eligible drug in order to substantially improve the accessibility and affordability of the eligible drug for patients and the state's health system; and (ii) has a reasonable expectation for successful implementation.

(d) If the commission determines that the proposed access and affordability improvement plan is unacceptable or incomplete, the commission may provide consultation on the criteria that have not been met and may allow an additional time period of not more than 30 calendar days for resubmission; provided, however, that all aspects of the access plan shall be proposed by the manufacturer and the commission shall not require specific elements for approval.

(e) Upon approval of the proposed access and affordability improvement plan, the commission shall notify the manufacturer to begin immediate implementation of the access and affordability improvement plan. Public notice shall be provided by the commission on its

website, identifying that the manufacturer is implementing an access and affordability improvement plan; provided, however, that upon the successful completion of the access and affordability improvement plan, the identity of the manufacturer shall be removed from the commission's website. All manufacturers implementing an approved access improvement plan shall be subject to additional reporting requirements and compliance monitoring as determined by the commission. The commission shall provide assistance to the manufacturer in the successful implementation of the access and affordability improvement plan.

(f) All manufacturers shall work in good faith to implement the access and affordability improvement plan. At any point during the implementation of the access and affordability improvement plan, the manufacturer may file amendments to the access improvement plan, subject to approval of the commission.

(g) At the conclusion of the timetable established in the access and affordability improvement plan, the manufacturer shall report to the commission regarding the outcome of the access and affordability improvement plan. If the commission determines that the access and affordability improvement plan was unsuccessful, the commission shall: (i) extend the implementation timetable of the existing access and affordability improvement plan; (ii) approve amendments to the access and affordability improvement plan as proposed by the manufacturer; (iii) require the manufacturer to submit a new access and affordability improvement plan; or (iv) waive or delay the requirement to file any additional access and affordability improvement plans.

(h) The commission shall submit a recommendation for proposed legislation to the joint committee on health care financing if the commission determines that further legislative

authority is needed to assist manufacturers with the implementation of access and affordability improvement plans or to otherwise ensure compliance with this section.

(i) An access and affordability improvement plan under this section shall remain confidential in accordance with section 2A.

(j) The commission may assess a civil penalty to a manufacturer of not more than $500,000, in each instance, if the commission determines that the manufacturer: (i) willfully neglected to file an access and affordability improvement plan with the commission under subsection (a); (ii) failed to file an acceptable access and affordability improvement plan in good faith with the commission; (iii) failed to implement the access and affordability improvement plan in good faith; or (iv) knowingly failed to provide information required by this section to the commission or knowingly falsified the information. The commission shall seek to promote compliance with this section and shall only impose a civil penalty as a last resort. Penalties collected under this subsection shall be deposited into the Prescription Drug Cost Assistance Trust Fund established in section 2RRRRR of chapter 29.

(k) If a manufacturer declines to enter into an access and affordability improvement plan under this section, the commission may publicly post the proposed value of the eligible drug, hold a public hearing on the proposed value of the eligible drug and solicit public comment. The manufacturer shall appear and testify at the public hearing held on the eligible drug's proposed value. Upon the conclusion of a public hearing under this subsection, the commission shall issue recommendations on ways to reduce the cost of an eligible drug for the purpose of improving patient access to the eligible drug. The recommendations shall be publicly posted on the commission's website and provided to the clerks of the house of representatives and senate, the

joint committee on health care financing and the house and senate committees on ways and means.

If a manufacturer is deemed to not be acting in good faith to develop an acceptable or complete access and affordability improvement plan, the commission may publicly post the proposed value of the eligible drug, hold a public hearing on the proposed value of the eligible drug and solicit public comment. The manufacturer shall appear and testify at any hearing held on the eligible drug's proposed value. Upon the conclusion of a public hearing under this subsection, the commission shall issue recommendations on ways to reduce the cost of an eligible drug for the purpose of improving patient access to the eligible drug. The recommendations shall be publicly posted on the commission's website and provided to the clerks of the house of representatives and senate, the joint committee on health care financing and the house and senate committees on ways and means.

Before making a determination that the manufacturer is not acting in good faith, the commission shall send a written notice to the manufacturer that the commission shall deem the manufacturer to not be acting in good faith if the manufacturer does not submit an acceptable access and affordability improvement plan within 30 days of receipt of notice; provided, however, that the commission shall not send a notice under this paragraph within 120 calendar days from the date that the commission issued its request that the manufacturer enter into the access and affordability improvement plan.

(l) The commission shall promulgate regulations necessary to implement this section.

SECTION 23. Section 1 of chapter 12C of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after the definition of "Ambulatory surgical center services" the following 3 definitions:-

"Average manufacturer price", the average price paid to a manufacturer for a drug in the commonwealth by a: (i) wholesaler for drugs distributed to pharmacies; and (ii) pharmacy that purchases drugs directly from the manufacturer.

"Biosimilar", a drug that is produced or distributed pursuant to a biologics license application approved under 42 U.S.C. 262(k)(3).

"Brand name drug", a drug that is: (i) produced or distributed pursuant to an original new drug application approved under 21 U.S.C. 355(c) except for: (a) any drug approved through an application submitted under section 505(b)(2) of the federal Food, Drug, and Cosmetic Act that is pharmaceutically equivalent, as that term is defined by the United States Food and Drug Administration, to a drug approved under 21 U.S.C. 355(c); (b) an abbreviated new drug application that was approved by the United States Secretary of Health and Human Services under section 505(c) of the federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(c), before the date of the enactment of the federal Drug Price Competition and Patent Term Restoration Act of 1984, Public Law 98-417, 98 Stat. 1585; or (c) an authorized generic as defined by 42 C.F.R. 447.502; (ii) produced or distributed pursuant to a biologics license application approved under 42 U.S.C. 262(a)(2)(C); or (iii) identified by the health benefit plan as a brand name drug based on available data resources such as Medi-Span.

SECTION 24. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "General health supplies, care or rehabilitative services and accommodations" the following definition:-

"Generic drug", a retail drug that is: (i) marketed or distributed pursuant to an abbreviated new drug application approved under 21 U.S.C. 355(j); (ii) an authorized generic as defined by 42 C.F.R. 447.502; (iii) a drug that entered the market before January 1, 1962 that was not originally marketed under a new drug application; or (iv) identified by the health benefit plan as a generic drug based on available data resources such as Medi-Span.

SECTION 25. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Patient-centered medical home" the following 2 definitions:-

"Pharmaceutical manufacturing company", an entity engaged in the: (i) production, preparation, propagation, compounding, conversion or processing of prescription drugs, directly or indirectly, by extraction from substances of natural origin, independently by means of chemical synthesis or by a combination of extraction and chemical synthesis; or (ii) packaging, repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that "pharmaceutical manufacturing company" shall not include a wholesale drug distributor licensed under section 36B of chapter 112 or a retail pharmacist registered under section 39 of said chapter 112.

"Pharmacy benefit manager", a person, business or other entity, however organized, that, directly or through a subsidiary, provides pharmacy benefit management services for prescription drugs and devices on behalf of a health benefit plan sponsor, including, but not limited to, a self-

insurance plan, labor union or other third-party payer; provided, however, that pharmacy benefit management services shall include, but not be limited to: (i) the processing and payment of claims for prescription drugs; (ii) the performance of drug utilization review; (iii) the processing of drug prior authorization requests; (iv) pharmacy contracting; (v) the adjudication of appeals or grievances related to prescription drug coverage contracts; (vi) formulary administration; (vii) drug benefit design; (viii) mail and specialty drug pharmacy services; (ix) cost containment; (x) clinical, safety and adherence programs for pharmacy services; and (xi) managing the cost of covered prescription drugs; provided further, that "pharmacy benefit manager" shall include a health benefit plan that does not contract with a pharmacy benefit manager and manages its own prescription drug benefits unless specifically exempted by the commission.

SECTION 26. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by adding the following definition:-

"Wholesale acquisition cost", shall have the same meaning as defined in 42 U.S.C. 1395w-3a(c)(6)(B).

SECTION 27. Section 3 of said chapter 12C, as so appearing, is hereby amended by inserting after the word "organizations", in lines 13 and 14, the following words:- , pharmaceutical manufacturing companies, pharmacy benefit managers.

SECTION 28. Said section 3 of said chapter 12C, as so appearing, is hereby further amended by striking out, in line 24, the words "and payer" and inserting in place thereof the following words:- , payer, pharmaceutical manufacturing company and pharmacy benefit manager.

SECTION 29. Section 5 of said chapter 12C, as so appearing, is hereby amended by striking out, in lines 11 and 12, the words “and public health care payers” and inserting in place thereof the following words:- , public health care payers, pharmaceutical manufacturing companies and pharmacy benefit managers.

SECTION 30. Said section 5 of said chapter 12C, as so appearing, is hereby further amended by striking out, in line 15, the words “and affected payers” and inserting in place thereof the following words:- affected payers, affected pharmaceutical manufacturing companies and affected pharmacy benefit managers.

SECTION 31. The first paragraph of section 7 of said chapter 12C, as so appearing, is hereby amended by adding the following sentence:- Each pharmaceutical and biopharmaceutical manufacturing company and pharmacy benefit manager shall pay to the commonwealth an amount for the estimated expenses of the center and for the other purposes described in this chapter.

SECTION 32. Said section 7 of said chapter 12C, as so appearing, is hereby further amended by striking out, in lines 8 and 42, the figure “33” and inserting in place thereof, in each instance, the following figure:- 25.

SECTION 33. Said section 7 of said chapter 12C, as so appearing, is hereby further amended by adding the following paragraph:-

The assessed amount for pharmaceutical and biopharmaceutical manufacturing companies and pharmacy benefit managers shall be not less than 25 per cent of the amount appropriated by the general court for the expenses of the center minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the commission's publication or dissemination

of reports and information; and (iii) federal matching revenues received for these expenses or received retroactively for expenses of predecessor agencies. Pharmaceutical and biopharmaceutical manufacturing companies and pharmacy benefit managers shall, in a manner and distribution determined by the center, pay to the commonwealth an amount of the estimated expenses of the center attributable to the center's activities under sections 3, 10A, 12 and 16. The assessed amount shall be based on business conducted in the commonwealth by the pharmaceutical and biopharmaceutical manufacturing company and pharmacy benefit manager. A pharmacy benefit manager that is also a surcharge payor subject to the preceding paragraph and manages its own prescription drug benefits shall not be subject to additional assessment under this paragraph.

SECTION 34. Said chapter 12C is hereby further amended by inserting after section 10 the following section:-

Section 10A. (a) The center shall promulgate the regulations necessary to ensure the uniform reporting of information from pharmaceutical manufacturing companies to enable the center to analyze: (i) year-over-year changes in wholesale acquisition cost and average manufacturer price for prescription drug products; (ii) year-over-year trends in net expenditures; (iii) net expenditures on subsets of biosimilar, brand name and generic drugs identified by the center; (iv) trends in estimated aggregate drug rebates, discounts or other remuneration paid or provided by a pharmaceutical manufacturing company to a pharmacy benefit manager, wholesaler, distributor, health carrier client, health plan sponsor or pharmacy in connection with utilization of the pharmaceutical drug products offered by the pharmaceutical manufacturing company; (v) discounts provided by a pharmaceutical manufacturing company to a consumer in connection with utilization of the pharmaceutical drug products offered by the pharmaceutical

manufacturing company, including any discount, rebate, product voucher, coupon or other reduction in a consumer's out-of-pocket expenses including co-payments and deductibles under section 3 of chapter 175H; (vi) research and development costs as a percentage of revenue; (vii) annual marketing and advertising costs, identifying costs for direct-to-consumer advertising; (viii) annual profits over the most recent 5-year period; (ix) disparities between prices charged to purchasers in the commonwealth and purchasers outside of the United States; and (x) any other information deemed necessary by the center.

The center shall require the submission of available data and other information from pharmaceutical manufacturing companies including, but not limited to: (i) wholesale acquisition costs and average manufacturer prices for prescription drug products as identified by the center; (ii) true net typical prices charged to pharmacy benefits managers by payor type for prescription drug products identified by the center, net of any rebate or other payments from the manufacturer to the pharmacy benefits manager and from the pharmacy benefits manager to the manufacturer; (iii) aggregate, company-level research and development costs to the extent attributable to a specific product and other relevant capital expenditures for the most recent year for which final audited data is available for prescription drug products as identified by the center; (iv) annual marketing and advertising expenditures; and (v) a description, absent proprietary information and written in plain language, of factors that contributed to reported changes in wholesale acquisition costs, net prices and average manufacturer prices for prescription drug products as identified by the center.

(b) The center shall promulgate the regulations necessary to ensure the uniform reporting of information from pharmacy benefit managers to enable the center to analyze: (i) trends in estimated aggregate drug rebates and other drug price reductions, if any, provided by a pharmacy

benefit manager to a health carrier client or health plan sponsor or passed through from a pharmacy benefit manager to a health carrier client or health plan sponsor in connection with utilization of drugs in the commonwealth offered through the pharmacy benefit manager and a measure of lives covered by each health carrier client or health plan sponsor in the commonwealth; (ii) pharmacy benefit manager practices with regard to drug rebates and other drug price reductions, if any, provided by a pharmacy benefit manager to a health carrier client or health plan sponsor or to consumers in the commonwealth or passed through from a pharmacy benefit manager to a health carrier client or health plan sponsor or to consumers in the commonwealth; and (iii) any other information deemed necessary by the center.

The center shall require the submission of available data and other information from pharmacy benefit managers including, but not limited to: (i) true net typical prices charged by pharmacy benefits managers for prescription drug products identified by the center, net of any rebate or other payments from the manufacturer to the pharmacy benefits manager and from the pharmacy benefits manager to the manufacturer; (ii) the amount of all rebates that the pharmacy benefit manager received from all pharmaceutical manufacturing companies for all health carrier clients in the aggregate and for each health carrier client or health plan sponsor individually, attributable to patient utilization in the commonwealth; (iii) the administrative fees that the pharmacy benefit manager received from all health carrier clients or health plan sponsors in the aggregate and for each health carrier client or health plans sponsors individually; (iv) the aggregate amount of all retained rebates that the pharmacy benefit manager received from all pharmaceutical manufacturing companies and did not pass through to each pharmacy benefit manager's health carrier client or health plan sponsor individually; (v) the aggregate amount of rebates a pharmacy benefit manager: (A) retains based on its contractual arrangement with each

health plan client or health plan sponsor individually; and (B) passes through to each health care client individually; (vi) the percentage of contracts that a pharmacy benefit manager holds where the pharmacy benefit manager: (A) retains all rebates; (B) passes all rebates through to the client; and (C) shares rebates with the client; and (vii) other information as determined by the center, including, but not limited to, pharmacy benefit manager practices related to spread pricing, administrative fees, claw backs and formulary placement.

(c) Except as specifically provided otherwise by the center or under this chapter, data collected by the center pursuant to this section from pharmaceutical manufacturing companies and pharmacy benefit managers shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66.

SECTION 35. Said chapter 12C is hereby further amended by striking out section 11, as so appearing, and inserting in place thereof the following section:-

Section 11. The center shall ensure the timely reporting of information required under sections 8, 9, 10 and 10A. The center shall notify private health care payers, providers, provider organizations, pharmacy benefit managers, pharmaceutical manufacturing companies and their parent organization and other affiliates of any applicable reporting deadlines. The center shall notify, in writing, a private health care payer, provider, provider organization, pharmacy benefit manager or pharmaceutical manufacturing company, and their parent organization and other affiliates, that has failed to meet a reporting deadline of such failure and that failure to respond within 2 weeks of the receipt of the notice may result in penalties. The center may assess a penalty against a private health care payer, provider, provider organization, pharmacy benefit manager or pharmaceutical manufacturing company, and their parent organization and other

affiliates, that fails, without just cause, to provide the requested information, including subsets of the requested information, within 2 weeks following receipt of the written notice required under this section, of not more than $2,000 per week for each week of delay after the 2-week period following receipt of the notice. Amounts collected under this section shall be deposited in the Healthcare Payment Reform Fund established in section 100 of chapter 194 of the acts of 2011.

SECTION 36. Section 12 of said chapter 12C, as so appearing, is hereby amended by striking out, in line 2, the words “and 10” and inserting in place thereof the following words:- , 10 and 10A.

SECTION 37. Subsection (a) of section 16 of said chapter 12C, as so appearing, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence:- The center shall publish an annual report based on the information submitted under: (i) sections 8, 9, 10 and 10A concerning health care provider, provider organization, private and public health care payer, pharmaceutical manufacturing company and pharmacy benefit manager costs and cost and price trends; (ii) section 13 of chapter 6D relative to market power reviews; and (iii) section 15 of said chapter 6D relative to quality data.

SECTION 38. Said section 16 of said chapter 12C, as so appearing, is hereby further amended by striking out, in line 18, the words “in the aggregate”.

SECTION 39. Said section 16 of said chapter 12C, as so appearing, is hereby further amended by inserting after the second paragraph the following paragraph:-

As part of its annual report, the center shall report on prescription drug utilization and spending for pharmaceutical drugs provided in an outpatient setting or sold in a retail setting for private and public health care payers, including, but not limited to, information sufficient to

show (i) highest utilization drugs; (ii) drugs with the greatest increases in utilization; (iii) drugs that are most impactful on plan spending, net of rebates; and (iv) drugs with the highest year-over-year price increases, net of rebates.

SECTION 40. Section 13 of chapter 17 of the General Laws, as so appearing, is hereby amended by adding the following subsection:-

(f) As used in this subsection, the following words shall have the following meanings unless the context clearly requires otherwise:

"Public health essential drug", a prescription drug, biologic or biosimilar approved by the United States Food and Drug Administration that: (i) appears on the Model List of Essential Medicines most recently adopted by the World Health Organization; or (ii) is deemed an essential medicine by the commission due to its efficacy in treating a life-threatening health condition or a chronic health condition that substantially impairs an individual's ability to engage in activities of daily living or because limited access to a certain population would pose a public health challenge.

The commission shall identify and publish a list of public health essential prescription drugs. The list shall be updated not less than annually and be made publicly available on the department's website; provided, however, that the commission may provide an interim listing of a public health essential drug prior to an annual update. The commission shall notify and forward a copy of the list to the health policy commission established under chapter 6D.

SECTION 41. Chapter 29 of the General Laws is hereby amending by inserting after section 2QQQQQ the following section:-

2RRRRR. (a) There shall be a Prescription Drug Cost Assistance Trust Fund. The secretary of health and human services shall administer the fund and shall make expenditures from the fund, without further appropriation, to provide financial assistance to state residents for the cost of prescription drugs through the prescription drug costs assistance program established under section 244 of chapter 111. For the purpose of this section “prescription drug” shall include the prescription drug and any drug delivery device needed to administer the drug that is not included as part of the underlying drug prescription.

The fund shall consist of: (i) revenue generated from the penalty established under chapter 63E; (ii) revenue from appropriations or other money authorized by the general court and specifically designated to be credited to the fund; and (iii) funds from public or private sources, including, but not limited to, gifts, grants, donations, rebates and settlements received by the commonwealth that are specifically designated to be credited to the fund. An amount equal to the total receipts deposited each quarter from the penalty on drug manufacturers for excessive price increases established under chapter 63E shall be transferred from the General Fund to the Prescription Drug Costs Assistance Trust Fund before the end of each fiscal year. Money remaining in the fund at the close of a fiscal year shall not revert to the General Fund and shall be available for expenditure in the following fiscal year.

(b) Annually, not later than March 1, the secretary shall report on the activities detailing the funds expenditures from the previous calendar year. The report shall include: (i) the number of individuals who received financial assistance from the fund; (ii) the breakdown of fund recipients by race, gender, age range, geographic region and income level; (iii) a list of all prescription drugs that were covered by money from the fund; and (iv) the total cost savings received by all fund recipients and the cost savings broken down by race, gender, age range and

income level. The report shall be submitted to the clerks of the senate and house of representatives, senate and house committees on ways and means and the joint committee on health care financing.

(c) The secretary shall promulgate regulations or issue other guidance for the expenditure of the funds under this section.

SECTION 42. Section 17G of chapter 32A of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by adding the following sentence:-

Coverage for insulin under this section shall not be subject to any deductible or co-insurance and any co-payment shall not exceed $25 per 30-day supply, regardless of the amount or type of insulin needed to fill an insured's prescription; provided, however, that nothing in this section shall prevent the commission and its contracted health benefit plans from reducing the co-payment for insulin for a 30-day supply below the amount specified in this section.

SECTION 43. Said chapter 32A, as so appearing, is hereby further amended by inserting after section 17R the following section:-

Section 17S. Any carrier offering a policy, contract or certificate of health insurance under this chapter shall provide coverage for the brand name drugs and generic drugs identified by the drug access program established in section 16DD in chapter 6A. Coverage for identified generic drugs shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible. Coverage for identified brand name drugs shall not be subject to any deductible or co-insurance and any co-payment shall not exceed $25 per 30-day supply.

Notwithstanding this section or any other general or special law to the contrary, coverage for insulin shall be provided under section 17G of this chapter.

SECTION 44. The General Laws are hereby amended by inserting after chapter 63D the following chapter:-

Chapter 63E. PENALTY ON DRUG MANUFACTURERS FOR EXCESSIVE PRICE INCREASES

Section 1. As used in this chapter, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Commissioner", the commissioner of revenue.

"Core consumer price index", the consumer price index for all urban consumers (CPI-U): U.S. city average, for all Items less food and energy, as reported by the U.S. Bureau of Labor Statistics.

"Drug", any medication, as identified by a National Drug Code, approved for sale by the U.S. Food and Drug Administration.

"Excessive price," the price of a drug that exceeds the sum of the reference price of that drug plus the three -year average of the core consumer price index, as measured on January 1 of the current calendar year.

"Excessive price increase", the amount by which the price of a drug exceeds the sum of the reference price of that drug plus the three-year average of the core consumer price index, as measured on January 1 of the current calendar year.

"Person", any natural person or legal entity.

"Price", the wholesale acquisition cost of a drug, per unit, as reported to the First Data Bank or other appropriate price compendium designated by the commissioner.

"Reference date", January 1 of the calendar year prior to the current calendar year.

"Reference price", the price of a drug on the reference date, or in the case of any drug first commercially marketed in the United States after the reference date, the price of the drug on the date when first marketed in the United States.

"Related party", an entity is a related party with respect to a person if that entity (i) belongs to the same affiliated group as that person under section 1504 of the Internal Revenue Code provided that the term 50 per cent shall be substituted for the term 80 per cent each time it appears in said section 1504, (ii) has a relationship with that person that is specified in subsections (b) and (c) of section 267 of the Internal Revenue Code, or (iii) is otherwise under common ownership and control with regard to that person; provided, that all references to the Internal Revenue Code in this definition refer to the Internal Revenue Code as amended and in effect for the taxable year.

"Unit", the lowest dispensable amount of a drug.

Section 2. (a) Any person who manufactures and sells drugs, directly or through another person, for distribution in the commonwealth and who establishes an excessive price for any such drug directly or in cooperation with a related party, shall pay a per unit penalty on all units of the drug ultimately dispensed or administered in the commonwealth. The penalty for each unit shall be 80 per cent of the excessive price increase for each unit.

(b) A person who establishes an excessive price for a drug as described in subsection (a) shall file a return as provided in section 4 declaring all units of excessively priced drug sold for distribution in the commonwealth during each calendar quarter. In the event that a person filing such a return pays a penalty with regard to one or more units of drug that are ultimately dispensed or administered outside of the commonwealth, the person may claim a credit for such penalty amounts on the return for the tax period during which such units are ultimately dispensed or administered.

Section 3. The penalty under section 2 shall apply for any calendar quarter only to a person who maintains a place of business in the commonwealth or whose total sales of all products, directly or through another person, for distribution in the commonwealth were more than $100,000 in the calendar year beginning with the reference date. The penalty shall not apply more than once to any unit of drug sold.

Section 4. Any person subject to the penalty under section 2 shall file a return with the commissioner and shall pay the penalty by the fifteenth day of the third month following the end of each calendar quarter, subject to such reasonable extensions of time for filing as the commissioner may allow. The return shall set out the person’s total sales subject to penalty in the immediately preceding calendar quarter and shall provide such other information as the commissioner may require.

Section 5. The penalty imposed under this chapter shall be in addition to, and not a substitute for or credit against, any other penalty, tax or excise imposed under the General Laws.

Section 6. The commissioner may disclose information contained in returns filed under this chapter to the department of public health, the executive office of health and human services,

or other appropriate agency for purposes of verifying that a filer's sales subject to penalty are properly declared and that all reporting is otherwise correct. Return information so disclosed shall remain confidential and shall not be public record.

Section 7. To the extent that a person subject to penalty under section 2 fails to pay amounts due under this chapter, a related party of such person that directly or indirectly distributes in the commonwealth any drug whose sales are subject to this chapter shall be jointly and severally liable for the penalty due.

Section 8. The commissioner may promulgate regulations for the implementation of this chapter.

SECTION 45. Chapter 94C of the General Laws is hereby amended by inserting after section 21B the following section:-

Section 21C. (a) For the purposes of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Cost sharing", amounts owed by a consumer under the terms of the consumer's health benefit plan as defined in section 1 of chapter 176O or as required by a pharmacy benefit manager as defined in section 1 of chapter 6D.

"Pharmacy retail price", the amount an individual would pay for a prescription medication at a pharmacy if the individual purchased that prescription medication at that pharmacy without using a health benefit plan as defined in section 1 of chapter 176O or any other prescription medication benefit or discount.

"Registered pharmacist", a pharmacist who holds a valid certificate of registration issued by the board of registration in pharmacy pursuant to section 24 of chapter 112.

(b) A pharmacy shall post a notice informing consumers that a consumer may request, at the point of sale, the current pharmacy retail price for each prescription medication the consumer intends to purchase. If the consumer's cost-sharing amount for a prescription medication exceeds the current pharmacy retail price, the pharmacist, or an authorized individual at the direction of a pharmacist, shall notify the consumer that the pharmacy retail price is less than the patient's cost-sharing amount. The pharmacist shall charge the consumer the applicable cost-sharing amount or the current pharmacy retail price for that prescription medication, as directed by the consumer.

A pharmacist shall not be subject to a penalty by the board of registration in pharmacy or a third party for failure to comply with this section.

(c) A contractual obligation shall not prohibit a pharmacist from complying with this section; provided however, that a pharmacist shall submit a claim to the consumer's health benefit plan or its pharmacy benefit manager if the pharmacist has knowledge that the prescription medication is covered under the consumer's health benefit plan.

(d) Failure to post notice pursuant to subsection (b) shall be an unfair or deceptive act of practice under chapter 93A.

SECTION 46. Chapter 111 of the General Laws is hereby amended by adding the following section:-

Section 244. (a) The department shall establish and administer a prescription drug cost assistance program, which shall be funded by the Prescription Drug Cost Assistance Trust Fund

established in section 2RRRRR of chapter 29. The program shall provide financial assistance for prescription drugs used to treat: (1) chronic respiratory conditions, including, but not limited to, chronic obstructive pulmonary disease and asthma; (2) chronic heart conditions, including, but not limited to, heart failure, coronary artery disease, hypertension and high blood pressure; (3) diabetes; and (4) any other chronic condition identified by the department that disproportionally impacts people of color or is a risk factor for increased COVID-19 complications; provided, that for paragraphs (1) and (3), "prescription drug" shall include the prescription drug and any drug delivery device needed to administer the drug that is not included as part of the underlying drug prescription. Such financial assistance shall cover the full cost of any co-payment, co-insurance or deductible for the prescription drug for an individual who is eligible for the program.

(b) An individual shall be eligible for the program if the individual: (1) is a resident of Massachusetts; (2) has a current prescription from a health care provider for a drug that is used to treat a chronic condition listed in subsection (a); (3) has a family income equal to or less than 500 per cent of the federal poverty level; and (4) is not enrolled in MassHealth.

(c) The department shall create an application process, which shall be available electronically and in hard copy form, to determine whether an individual meets the program eligibility requirements under subsection (b). Upon receipt of such application, the department shall determine an applicant's eligibility and notify the applicant of the department's determination within 10 business days. If necessary for its determination, the department may request additional information from the applicant; provided, that the department shall notify the applicant within 5 business days of receipt of the original application as to what specific additional information is being requested. If additional information is being requested, the department shall, within 3 business days of receipt of the additional information, determine

whether the applicant is eligible for the program and notify the applicant of the department's determination.

If the department determines that an applicant is not eligible for the program, the department shall notify the applicant and shall include in the department's notification the specific reasons why the applicant is not eligible. The applicant may appeal this determination to the department within 30 days of receiving such notification.

If the department determines that an applicant is eligible for the program, the department shall provide the applicant with a prescription drug cost assistance program identification card, which shall clearly indicate that the department has determined that the applicant is eligible for the program; provided, that the program identification card shall include, at a minimum: (1) the applicant's full name, and (2) the full name of the prescription drug that the applicant is eligible to receive under the program without having to pay a co-payment, co-insurance or deductible. An applicant's program identification card shall be valid for 12 months and shall be renewable upon a redetermination of program eligibility.

(d) An individual with a valid program identification card issued under subsection (c) may present such card at any pharmacy in the commonwealth and, upon presentation of such card, the pharmacy shall fill the individual's prescription and provide the prescribed drug to the individual without requiring the individual to pay a co-payment, co-insurance or deductible; provided, that the pharmacy shall be reimbursed for its costs by the Prescription Drug Cost Assistance Trust Fund established in section 2RRRRR of chapter 29, in a manner determined by the department, in an amount equal to what the pharmacy would have received had the individual been required to pay a co-payment, co-insurance or deductible.

(e) The department, in collaboration with the division of insurance and board of registration in pharmacy, shall develop and implement a plan to educate consumers, pharmacists, providers, hospitals and insurers regarding eligibility for and enrollment in the program under this section. The plan shall include, but not be limited to, appropriate staff training, notices provided to consumers at the pharmacy, and a designated website with information for consumers, pharmacists and other health care professionals. The plan shall be developed in consultation with groups representing consumers, pharmacists, providers, hospitals and insurers.

(f) The department shall compile a report detailing information about the program from the previous calendar year. The report shall include: (1) the number of applications received, approved, denied and appealed; (2) the total number of applicants approved, and the number of applicants approved broken down by race, gender, age range and income level; (3) a list of all prescription drugs that qualify for the program under subsection (b) and a list of prescription drugs that applicants actually received financial assistance for; and (4) the total cost savings received by all approved applicants, and the cost savings broken down by race, gender, age range and income level. The report shall be submitted annually, by March 1, to the clerks of the senate and house of representatives, the chairs of the joint committee on ways and means and the chairs of the joint committee on health care financing.

(g) The department shall promulgate regulations or issue other guidance for the implementation and enforcement of this section.

SECTION 47. Section 10C of chapter 118E of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by adding the following sentence:-

Coverage for insulin under this section shall not be subject to any deductible or co-insurance and any co-payment shall not exceed $25 per 30-day supply, regardless of the amount or type of insulin needed to fill an insured's prescription; provided, however, that nothing in this section shall prevent the division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract with the division, a Medicaid managed care organization or a primary care clinician plan, from reducing the co-payments for insulin for a 30-day supply below the amount specified in this section.

SECTION 48. Said chapter 118E, as so appearing, is hereby amended by inserting after section 10N the following section:-

Section 10O. Any carrier offering a policy, contract or certificate of health insurance under this chapter shall provide coverage for the brand name drugs and generic drugs identified by the drug access program established in section 16DD in chapter 6A. Coverage for identified generic drugs shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible. Coverage for identified brand name drugs shall not be subject to any deductible or co-insurance and any co-payment shall not exceed $25 per 30-day supply.

Notwithstanding this section or any other general or special law to the contrary, coverage for insulin shall be provided under section 10C of this chapter.

SECTION 49. Section 47N of chapter 175 of the General Laws, as so appearing, is hereby amended by adding the following paragraph:-

Coverage for insulin under this section shall not be subject to any deductible or co-insurance and any co-payment shall not exceed $25 per 30-day supply, regardless of the amount or type of insulin needed to fill an insured's insulin prescription; provided, however, that nothing in this section shall prevent an individual policy of accident and sickness insurance issued under section 108 that provides hospital expense and surgical expense insurance or a group blanket or general policy of accident and sickness insurance issued under section 110 that provides hospital expense and surgical expense insurance that is issued or renewed within or without the commonwealth, from reducing the co-payment for insulin for a 30-day supply below the amount specified in this section.

SECTION 50. Said chapter 175, as so appearing, is hereby further amended by inserting after section 47PP the following new section:-

Section 47QQ. Any carrier offering a policy, contract or certificate of health insurance under this chapter shall provide coverage for the brand name drugs and generic drugs identified by the drug access program established in section 16DD in chapter 6A. Coverage for identified generic drugs shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible. Coverage for identified brand name drugs shall not be subject to any deductible or co-insurance and any co-payment shall not exceed $25 per 30-day supply.

Notwithstanding this section or any other general or special law to the contrary, coverage for insulin shall be provided under section 47N of this chapter.

SECTION 51. Section 226 of said chapter 175 is hereby repealed.

SECTION 52. Section 8P of chapter 176A of the General Laws, as so appearing, is hereby amended by adding the following paragraph:-

Coverage for insulin under this section shall not be subject to any deductible or co-insurance and any co-payment shall not exceed $25 per 30-day supply, regardless of the amount or type of insulin needed to fill an insured's insulin prescription; provided, however, that nothing in this section shall prevent a contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within or without the commonwealth, from reducing the co-payment for insulin for a 30-day supply below the amount specified in this section.

SECTION 53. Said chapter 176A, as so appearing, is hereby further amended by inserting after section 8QQ the following new section:-

Section 8RR. Any carrier offering a policy, contract or certificate of health insurance under this chapter shall provide coverage for the brand name drugs and generic drugs identified by the drug access program established in section 16DD in chapter 6A. Coverage for identified generic drugs shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible. Coverage for identified brand name drugs shall not be subject to any deductible or co-insurance and any co-payment shall not exceed $25 per 30-day supply.

Notwithstanding this section or any other general or special law to the contrary, coverage for insulin shall be provided under section 8P of this chapter.

SECTION 54. Section 4S of chapter 176B of the General Laws, as so appearing, is hereby amended by adding the following sentence:-

Coverage for insulin under this section shall not be subject to any deductible or co-insurance and any co-payment shall not exceed $25 per 30-day supply, regardless of the amount or type of insulin needed to fill an insured's insulin prescription; provided, however, that nothing in this section shall prevents a subscription certificate under an individual or group medical service agreement that is issued or renewed within or without the commonwealth, from reducing the co-payment for insulin for a 30-day supply below the amount specified in this section.

SECTION 55. Said chapter 176B, as so appearing, is hereby further amended by inserting after section 4QQ the following new section:-

Section 4RR. Any carrier offering a policy, contract or certificate of health insurance under this chapter shall provide coverage for the brand name drugs and generic drugs identified by the drug access program established in section 16DD in chapter 6A. Coverage for identified generic drugs shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible. Coverage for identified brand name drugs shall not be subject to any deductible or co-insurance and any co-payment shall not exceed $25 per 30-day supply.

Notwithstanding this section or any other general or special law to the contrary, coverage for insulin shall be provided under section 4S of this chapter.

SECTION 56. Section 4H of chapter 176G of the General Laws, as so appearing, is hereby amended by adding the following paragraph:-

Coverage for insulin under this section shall not be subject to any deductible or co-insurance and any co-payment shall not exceed $25 per 30-day supply, regardless of the amount or type of insulin needed to fill an insured's insulin prescription; provided, however, that nothing

in this section shall prevent any individual or group health maintenance contract that is issued or renewed within or without the commonwealth, from reducing the co-payment for insulin for a 30-day supply below the amount specified in this section.

SECTION 57. Said chapter 176G, as so appearing, is hereby further amended by inserting after section 4GG the following new section:-

Section 4HH. Any carrier offering a policy, contract or certificate of health insurance under this chapter shall provide coverage for the brand name drugs and generic drugs identified by the drug access program established in section 16DD in chapter 6A. Coverage for identified generic drugs shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible. Coverage for identified brand name drugs shall not be subject to any deductible or co-insurance and any co-payment shall not exceed $25 per 30-day supply.

Notwithstanding this section or any other general or special law to the contrary, coverage for insulin shall be provided under section 4H of this chapter.

SECTION 58. Section 2 of chapter 176O of the General Laws, as so appearing, is hereby amended by adding the following subsection:-

(i) Every 3 years, a carrier that contracts with a pharmacy benefit manager shall coordinate an audit of the operations of the pharmacy benefit manager to ensure compliance with this chapter and to examine the pricing and rebates applicable to prescription drugs that are provided to the carrier’s covered persons.

SECTION 59. Said chapter 176O, as so appearing, is hereby further amended by inserting after section 22 the following section:-

Section 22A. Notwithstanding any other general or special law to the contrary, each carrier shall require that a pharmacy benefit manager receive a license from the division under chapter 176X as a condition of contracting with that carrier.

SECTION 60. Said chapter 176O as so appearing, is hereby further amended by adding the following section:-

Section 30. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Cost-sharing", an amount owed by an individual under the terms of the individual's health benefit plan.

"Pharmacy retail price", the amount an individual would pay for a prescription medication at a pharmacy if the individual purchased that prescription medication at that pharmacy without using a health benefit plan or any other prescription medication benefit or discount.

(b) At the point of sale, a pharmacy shall charge an individual the: (i) appropriate cost-sharing amount; or (ii) pharmacy retail price, whichever is the lowest; provided, however, that a carrier, or an entity that manages or administers benefits for a carrier, shall not require an individual to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of the: (a) individual's cost share; or (b) pharmacy retail price.

(c) A contract shall not: (i) prohibit a pharmacist from complying with this section; or (ii) impose a penalty on the pharmacist or pharmacy for complying with this section.

SECTION 61. The General Laws are hereby amended by inserting after chapter 176W the following chapter:-

Chapter 176X. LICENSING AND REGULATION OF PHARMACY BENEFIT MANAGERS.

Section 1. As used in this chapter, the following words shall have the following meanings, unless the context clearly requires otherwise:-

“Carrier”, as defined in section 1 of chapter 176O “Commissioner”, the commissioner of the division of insurance.

“Cost-sharing requirement”, any copayment, coinsurance, deductible, or annual limitation on cost-sharing (including a limitation subject to 42 U.S.C. §§ 18022(c) and 300gg-6(b)), required by or on behalf of an insured in order to receive specific health care services, including a prescription drug, covered by a health benefit plan .

“Division”, the division of insurance.

“Health benefit plan”, as defined in section 1 of chapter 176O

“Health care services”, supplies, care and services of a medical, surgical, optometric, dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive, or geriatric nature including, but not limited to, inpatient and outpatient acute hospital care and services, services provided by a community health center or by a sanatorium, as

included in the definition of “hospital” in Title XVIII of the federal Social Security Act, and treatment and care compatible with such services or by a health maintenance organization.

“Insured”, an enrollee, covered person, insured, member, policyholder or subscriber of a carrier, including an individual whose eligibility as an insured of a carrier is in dispute or under review, or any other individual whose care may be subject to review by a utilization review program or entity as described under other provisions of this chapter.

“Mail order pharmacy”, a pharmacy whose primary business is to receive prescriptions by mail, telefax or through electronic submissions and to dispense medication to insureds through the use of the United States mail or other common or contract carrier services and that provides any consultation with patients electronically rather than face to face.

“Network”, as defined in section 1 of chapter 176O.

“Network pharmacy”, a retail or other licensed pharmacy provider that contracts with a pharmacy benefit manager.

“Person”, a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not-for-profit corporation, unincorporated organization, government or governmental subdivision or agency.

“Pharmacy”, a facility, either physical or electronic, under the direction or supervision of a registered pharmacist which is authorized to dispense prescription drugs and has entered into a network contract with a pharmacy benefit manager or a carrier.

“Pharmacy benefit manager”, a person, business or other entity, however organized, that directly or through a subsidiary provides pharmacy benefit management services for prescription

drugs and devices on behalf of a health benefit plan sponsor, including, but not limited to, a self-insurance plan, labor union or other third-party payer; provided, however, that pharmacy benefit management services shall include, but not be limited to: (i) the processing and payment of claims for prescription drugs; (ii) the performance of drug utilization review; (iii) the processing of drug prior authorization requests; (iv) pharmacy contracting; (v) the adjudication of appeals or grievances related to prescription drug coverage contracts; (vi) formulary administration; (vii) drug benefit design; (viii) mail and specialty drug pharmacy services; (ix) cost containment; (x) clinical, safety and adherence programs for pharmacy services; and (xi) managing the cost of covered prescription drugs; provided further, that "pharmacy benefit manager" shall include a health benefit plan that does not contract with a pharmacy benefit manager and manages its own prescription drug benefits unless specifically exempted by the commission.

"Pharmacy benefit services" shall include, but not be limited to, formulary administration; drug benefit design; pharmacy network contracting; pharmacy claims processing; mail and specialty drug pharmacy services; and cost containment, clinical, safety, adherence programs for pharmacy services, and any other pharmacy benefit service that the commissioner deems appropriate. For the purposes of the chapter, a health benefit plan that does not contract with a pharmacy benefit manager shall be a pharmacy benefit manager.

"Rebates or fees", all fees or price concessions paid by a manufacturer to a pharmacy benefit manager or carrier, including rebates, discounts, and other price concessions that are based on actual or estimated utilization of a prescription drug. Rebates also include price concessions based on the effectiveness a drug as in a value-based or performance-based contract.

"Retail pharmacy", as defined in section 39D of chapter 112.

"Spread pricing" means the practice of a pharmacy benefit manager retaining an additional amount of money in addition to the amount paid to the pharmacy to fill a prescription.

"Steering", a practice employed by a pharmacy benefit manager or carrier that channels a prescription to a pharmacy in which a pharmacy benefit manager or carrier has an ownership interest, and includes but is not limited to retail, mail-order, or specialty pharmacies.

Section 2. (a) Any pharmacy benefit manager contracting with a pharmacy that operates in the commonwealth shall comply with the provisions of this chapter.

(b) A pharmacy benefit manager shall receive a license from the division before conducting business in the commonwealth. A license granted pursuant to this section is not transferable.

(c) A license may be granted only when the division is satisfied that the entity possesses the necessary organization, background expertise, and financial integrity to supply the services sought to be offered.

(d) The division may issue a license subject to restrictions or limitations upon the authorization, including the type of services that may be supplied or the activities in which the entity may be engaged.

(e) A license shall be valid for a period of three years. The commissioner shall charge application and renewal fees in the amount of $25,000

(f) The division shall develop an application for licensure that includes at least the following information: (i) the name of the pharmacy benefit manager; (ii) the address and contact telephone number for the pharmacy benefit manager; (iii) the name and address of the pharmacy

benefit manager's agent for service of process in the commonwealth; (iv) the name and address of each person beneficially interested in the pharmacy benefit manager; and (v) the name and address of each person with management or control over the pharmacy benefit manager.

(g) The division may suspend, revoke, or place on probation a pharmacy benefit manager license under any of the following circumstances: (i) the pharmacy benefit manager has engaged in fraudulent activity that constitutes a violation of state or federal law; (ii) the division received consumer complaints that justify an action under this chapter to protect the safety and interests of consumers; (iii) the pharmacy benefit manager fails to pay an application fee for the license; or (iv) the pharmacy benefit manager fails to comply with a requirement set forth in this chapter.

(h) If an entity performs the functions of pharmacy benefit manager acts without registering, it will be subject to a fine of $5,000 per day for the period they are found to be in violation.

Section 3

(a) (i) The pharmacy benefit manager shall have a duty and obligation to perform pharmacy benefit services with care, skill, prudence, diligence, and professionalism.

(ii) In addition to the duties as may be prescribed by regulation:

(1) A pharmacy benefit manager interacting with a covered individual shall have the same duty to a covered individual as the health plan for whom it is performing pharmacy benefit services.

(2) A pharmacy benefit manager shall have a duty of good faith and fair dealing with all parties, including but not limited to covered individuals and pharmacies, with whom it interacts in the performance of pharmacy benefit services.

Section 4

(a) A pharmacy benefit manager shall provide a reasonably adequate and accessible pharmacy benefit manager network for the provision of prescription drugs, which provides for convenient patient access to pharmacies within a reasonable distance from a patient's residence.

(b) A pharmacy benefit manager may not deny a pharmacy the opportunity to participate in a pharmacy benefit manager network at preferred participation status if the pharmacy is willing to accept the terms and conditions that the pharmacy benefit manager has established for other pharmacies as a condition of preferred network participation status.

(c) A mail-order pharmacy shall not be included in the calculations for determining pharmacy benefit manager network adequacy under this section.

Section 5.

(a) After the date of receipt of a clean claim for payment made by a pharmacy, a pharmacy benefit manager shall not retroactively reduce payment on the claim, either directly or indirectly, through aggregated effective rate, direct or indirect remuneration, quality assurance program or otherwise, except if the claim is found not to be a clean claim during the course of a routine audit performed pursuant to an agreement between the pharmacy benefit manager and the pharmacy. When a pharmacy adjudicates a claim at the point of sale, the reimbursement amount provided to the pharmacy by the pharmacy benefit manager shall constitute a final

reimbursement amount. Nothing in this section shall be construed to prohibit any retroactive increase in payment to a pharmacy pursuant to a contract between the pharmacy benefit manager or a pharmacy.

(b) For the purpose of this section, "clean claim" means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or other circumstance requiring special treatment, including, but not limited to, those listed in subsection (d) of this section, that prevents timely payment from being made on the claim.

(c) A pharmacy benefit manager shall not recoup funds from a pharmacy in connection with claims for which the pharmacy has already been paid unless the recoupment is:

(1) otherwise permitted or required by law; or

(2) the result of an audit, performed pursuant to a contract between the pharmacy benefit manager and the pharmacy; or

(d) The provisions of this section shall not apply to an investigative audit of pharmacy records when:

(1) fraud, waste, abuse or other intentional misconduct is indicated by physical review or review of claims data or statements; or

(2) other investigative methods indicate a pharmacy is or has been engaged in criminal wrongdoing, fraud or other intentional or willful misrepresentation.

(e) No pharmacy benefit manager shall charge or collect from an individual a copayment or cost-sharing that exceeds the contracted amount by the pharmacy for which the pharmacy is

paid. If an individual pays a copayment, the pharmacy shall retain the adjudicated costs and the pharmacy benefit manager shall not redact or recoup the adjudicated cost.

Section 6

(a) As used in this section:

(1) "Generically equivalent drug", a drug that is pharmaceutically and therapeutically equivalent to the drug prescribed;

(2)(A) "Maximum allowable cost list", a listing of drugs or other methodology used by a pharmacy benefit manager, directly or indirectly, setting the maximum allowable payment to a pharmacy or pharmacist for a generic drug, brand-name drug, biologic product, or other prescription drug.

(B) Maximum allowable cost list includes without limitation:

(i) Average acquisition cost, including national average drug acquisition cost;

(ii) Average manufacturer price;

(iii) Average wholesale price;

(iv) Brand effective rate or generic effective rate;

(v) Discount indexing;

(vi) Federal upper limits;

(vii) Wholesale acquisition cost; and

(viii) Any other term that a pharmacy benefit manager or a carrier may use to establish reimbursement rates to a pharmacist or pharmacy for pharmacist services;

(3) “Pharmaceutical wholesaler”, as defined in section 36A of chapter 112;

(4) “Pharmacist”, a pharmacist who, pursuant to the provisions of M.G.L. c. 112, § 24, is registered by the Board to practice pharmacy;

(5) “Pharmacist services”, products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy as defined in section 39D of chapter 112;

(6) “Pharmacy”, shall have the same meaning as defined in section 39D of chapter 112;

(7) “Pharmacy acquisition cost” means the amount that a pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy's billing invoice;

(8) “Pharmacy benefit manager”, as defined in section 1 of chapter 176X;

(9) “Pharmacy benefit manager affiliate”, a pharmacy or pharmacist that directly or indirectly, through one (1) or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefits manager; and

(10) “Pharmacy benefit plan or program”, a plan or program that pays for, reimburses, covers the cost of, or otherwise provides for pharmacist services to individuals who reside in or are employed in the commonwealth.

(b) Before a pharmacy benefit manager places or continues a particular drug on a maximum allowable cost list, the drug:

(1) If the drug is a generically equivalent drug, it shall be listed as therapeutically equivalent and pharmaceutically equivalent A or B rated in the United States Food and Drug Administration's most recent version of the Orange Book or Green Book or have an NR or NA rating by Medi-Span, Gold Standard, or a similar rating by a nationally recognized reference;

(2) Shall be available for purchase by each pharmacy in the state from national or regional wholesalers operating in the commonwealth; and

(3) Shall not be obsolete.

(c) A pharmacy benefit manager shall:

(1) Provide access to its maximum allowable cost list to each pharmacy subject to the maximum allowable cost list;

(2) Update its maximum allowable cost list on a timely basis, but in no event longer than seven (7) calendar days from an increase of ten per cent or more in the pharmacy acquisition cost from sixty per cent or more of the pharmaceutical wholesalers doing business in the state or a change in the methodology on which the maximum allowable cost list is based or in the value of a variable involved in the methodology;

(3) Provide a process for each pharmacy subject to the maximum allowable cost list to receive prompt notification of an update to the maximum allowable cost list; and

(4)(A)(i) Provide a reasonable administrative appeal procedure to allow pharmacies to challenge maximum allowable cost list and reimbursements made under a maximum allowable cost list for a specific drug or drugs as:

(a) Not meeting the requirements of this section; or

(b) Being below the pharmacy acquisition cost.

(ii) The reasonable administrative appeal procedure shall include the following:

(a) A dedicated telephone number, email address, and website for the purpose of submitting administrative appeals;

(b) The ability to submit an administrative appeal directly to the pharmacy benefit manager regarding the pharmacy benefits plan or program or through a pharmacy service administrative organization; and

(c) No less than thirty business days to file an administrative appeal.

(B) The pharmacy benefit manager shall respond to the challenge under subdivision (c)(4)(A) of this section within thirty business days after receipt of the challenge.

(C) If a challenge is made under subdivision (c)(4)(A) of this section, the pharmacy benefit manager shall within thirty business days after receipt of the challenge either:

(i) If the appeal is upheld:

(a) Make the change in the maximum allowable cost list payment to at least the pharmacy acquisition cost;

(b) Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question;

(c) Provide the National Drug Code that the increase or change is based on to the pharmacy or pharmacist; and

(d) Make the change under subdivision (c)(4)(C)(i)(a) of this section effective for each similarly situated pharmacy as defined by the payor subject to the maximum allowable cost list;

(ii) If the appeal is denied, provide the challenging pharmacy or pharmacist the National Drug Code and the name of the national or regional pharmaceutical wholesalers operating in the commonwealth that have the drug currently in stock at a price below the maximum allowable cost as listed on the maximum allowable cost list; or

(iii) If the National Drug Code provided by the pharmacy benefit manager is not available below the pharmacy acquisition cost from the pharmaceutical wholesaler from whom the pharmacy or pharmacist purchases the majority of prescription drugs for resale, then the pharmacy benefit manager shall adjust the maximum allowable cost as listed on the maximum allowable cost list above the challenging pharmacy's pharmacy acquisition cost and permit the pharmacy to reverse and rebill each claim affected by the inability to procure the drug at a cost that is equal to or less than the previously challenged maximum allowable cost.

(d)(1) A pharmacy benefit manager shall not reimburse a pharmacy or pharmacist in the commonwealth an amount less than the amount that the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate for providing the same pharmacist services.

(2) The amount shall be calculated on a per unit basis based on the same generic product identifier or generic code number.

(e) A pharmacy or pharmacist may decline to provide the pharmacist services to a patient or pharmacy benefit manager if, as a result of a maximum allowable cost list, a pharmacy or pharmacist is to be paid less than the pharmacy acquisition cost of the pharmacy providing pharmacist services.

(f) This section does not apply to a maximum allowable cost list maintained by MassHealth or the division of insurance.

(g)(1)A violation of this section shall constitute an unfair or deceptive act or practice pursuant to chapter 93A.

Section 7.

(a) No pharmacy benefit manager or representative of a pharmacy benefit manager shall conduct spread pricing in the commonwealth.

(b) A pharmacy benefit manager or representative of a pharmacy benefit manager that violates this section shall be subject to the surcharge under section 8 of chapter 176X.

(c) A pharmacy benefit manager shall report to the commissioner on a quarterly basis for each healthcare insurer the following information:

(A) The aggregate number of rebates received by the pharmacy benefit manager;

(B) The aggregate number of rebates distributed to the appropriate healthcare insurer;

(C) The aggregate number of rebates passed on to an insured of each healthcare insurer at the point of sale that reduced the insured's applicable deductible, copayment, coinsurance, or other cost-sharing amount;

(D) The individual and aggregate amount paid by the healthcare insurer to the pharmacy benefit manager for pharmacist services itemized by pharmacy, by product, and by goods and services; and

(E) The individual and aggregate amount a pharmacy benefit manager paid for pharmacist services itemized by pharmacy, by product, and by goods and services.

(d) The commissioner, in consultation with the health policy commission and the center for health information and analysis, shall annually report on the rebates and amounts reported under subsection (c), which shall be public record.

Section 8.

(a) A pharmacy benefits manager that engages in the practices of (i) spread pricing; (ii) steering; or (iii) imposing point-of-sale fees or retroactive fees shall be subject to a surcharge payable to the division of 10 percent on the aggregate dollar amount it reimbursed pharmacies in the previous calendar year for prescription drugs in the commonwealth.

(b) By March 1 of each year, a pharmacy benefit manager shall provide a letter to the commissioner attesting as to whether or not, in the previous calendar year, it engaged in the any of the practices under subsection (a). The pharmacy benefit manager shall also submit to the commissioner, in a form and manner and by a date specified by the commissioner, data detailing all prescription drug claims it administered in the commonwealth for insured residents on behalf of each health plan client and any other data the commissioner deems necessary to evaluate whether a pharmacy benefit manager may be engaged in any of the practices under subsection (a)

(c) By April 1 of each year, a pharmacy benefit manager shall pay into the general fund the surcharge owed, if any, as contained in the report submitted pursuant to subsection (b) of this section.

(d) Nothing in this section shall be construed to authorize the practices of steering or imposing point-of-sale fees or retroactive fees where otherwise prohibited by law.

(e) The commissioner, in consultation with the health policy commission and the center for health information and analysis, shall prepare an aggregate report reflecting the total number of prescriptions administered by the reporting pharmacy benefit manager with the total sum due to the commonwealth, which shall be public record.

Section 9.

(a) Any person operating a health plan whose contracted pharmacy benefits manager engages in the practices of (i) spread pricing; (ii) steering; or (iii) imposing point-of-sale fees or retroactive fees in connection with its health plans shall be subject to a surcharge payable to the division of 10 percent on the aggregate dollar amount its pharmacy benefit manager reimbursed pharmacies on its behalf in the previous calendar year for prescription drugs in the commonwealth.

(b) By March 1 of each year, any person operating a health plan and licensed in the commonwealth that utilizes a contracted pharmacy benefit manager shall provide a letter to the commissioner attesting as to whether or not, in the previous calendar year, its contracted pharmacy benefit manager engaged in any of the practices under subsection (a) in connection with its health plans. The health plan shall also submit to the commissioner, in a form and manner and by a date specified by the commissioner, data detailing all prescription drug claims its contracted pharmacy benefit manager administered in the commonwealth for insured residents and any other data the commissioner deems necessary to evaluate whether a health plan's pharmacy benefit manager may be engaged in any of the practices under subsection (a).

(c) By April 1 of each year, any person operating a health plan and licensed under this title shall pay into the general fund the surcharge owed, if any, as contained in the report submitted pursuant to subsection (b) of this section.

(d) Nothing in this section shall be construed to authorize the practices of steering or imposing point-of-sale fees or retroactive fees where otherwise prohibited by law.

(e) The commissioner, in consultation with the health policy commission and the center for health information and analysis, shall prepare an aggregate report reflecting the total number of prescriptions administered by the reporting health plan along with the total sum due to the commonwealth, which shall be public record.

Section 10.

When calculating an insured's contribution to any applicable cost sharing requirement, a pharmacy benefit manager shall include any cost-sharing amounts paid by the insured or on behalf of the insured by another person.

Section 11.

(a) A pharmacy benefit manager shall conduct an audit of the records of a pharmacy in accordance with paragraphs (1) to (13), inclusive.

(1) The contract between a pharmacy and a pharmacy benefit manager shall identify and describe the audit procedures in detail.

(2) With the exception of an investigative fraud audit, the auditor shall give the pharmacy written notice at least 2 weeks prior to conducting the initial on-site audit for each audit cycle.

(3) A pharmacy benefit manager shall not audit claims beyond 2 years prior to the date of audit.

(4) The auditor shall not interfere with the delivery of pharmacist services to a patient and shall make a reasonable effort to minimize the inconvenience and disruption to the pharmacy operations during the audit process.

(5) Any audit that involves clinical or professional judgment shall be conducted by, or in consultation with, a licensed pharmacist from any state.

(6) A finding of an overpayment or underpayment shall be based on the actual overpayment or underpayment. A statistically sound calculation for overpayment or underpayment may be used to determine recoupment as part of a settlement as agreed to by the pharmacy.

(7) The auditor shall audit each pharmacy under the same standards and parameters with which they audit other similarly situated pharmacies.

(8) An audit shall not be initiated or scheduled during the first 5 calendar days of any month for any pharmacy that averages more than 600 prescriptions per week without the pharmacy's consent.

(9) A preliminary audit report shall be delivered to the pharmacy not later than 30 days after the conclusion of the audit.

(10) The preliminary audit report shall be signed and shall include the signature of any pharmacist participating in the audit.

(11) A pharmacy benefit manager shall not withhold payment to a pharmacy for reimbursement claims as a means to recoup money until after the final internal disposition of an audit, including the appeals process, as provided in subsection (b), unless fraud or misrepresentation is reasonably suspected, or the discrepant amount exceeds $15,000.

(12) The auditor shall provide a copy of the final audit report to the pharmacy and plan sponsor within 30 days following the pharmacy's receipt of the signed preliminary audit report or the completion of the appeals process, as provided in subsection (b), whichever is later.

(13) No auditing company or agent shall receive payment based upon a percentage of the amount recovered or other financial incentive tied to the findings of the audit.

(b)(1) Each auditor shall establish an appeals process under which a pharmacy may appeal findings in a preliminary audit.

(2) To appeal a finding, a pharmacy may use the records of a hospital, physician, or other authorized prescriber to validate the record with respect to orders or refills of prescription drugs or devices.

(3) A pharmacy shall have 30 days to appeal any discrepancy found during the preliminary audit.

(4) The National Council for Prescription Drug Programs or any other recognized national industry standard shall be used to evaluate claims submission and product size disputes.

(5) If an audit results in the identification of any clerical or record-keeping errors in a required document or record, the pharmacy shall not be subject to recoupment of funds by the pharmacy benefit manager; provided, that the pharmacy may provide proof that the patient

received the medication billed to the plan via patient signature logs or other acceptable methods, unless there is financial harm to the plan or errors that exceed the normal course of business.

(c) This section shall not apply to any audit or investigation of a pharmacy that involves potential fraud, willful misrepresentation or abuse, including, but not limited to, investigative audits or any other statutory or regulatory provision which authorizes investigations relating to insurance fraud.

(d) This section shall not apply to a public health care payer, as defined in section 1 of chapter 12C.

(e) The commissioner shall promulgate regulations to enforce this section.

Section 12.

(a) The commissioner may make an examination of the affairs of a Pharmacy Benefit Manager when the commissioner deems prudent but not less frequently than once every 3 years. The focus of the examination shall be to ensure that a pharmacy benefit manager is able to meet its responsibilities under contracts with licensed carriers. The examination shall be conducted according to the procedures set forth in subsection (6) of section 4 of chapter 175.

(b) The commissioner, a deputy or an examiner may conduct an on-site examination of each pharmacy benefit manager in the commonwealth to thoroughly inspect and examine its affairs.

(c) The charge for each such examination shall be determined annually according to the procedures set forth in subsection (6) of section 4 of chapter 175.

(d) Not later than 60 days following completion of the examination, the examiner in charge shall file with the commissioner a verified written report of examination under oath. Upon receipt of the verified report, the commissioner shall transmit the report to the pharmacy benefit manager examined with a notice which shall afford the pharmacy benefit manager examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report. Within 30 days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall consider and review the reports together with any written submissions or rebuttals and any relevant portions of the examiner's work papers and enter an order:

(i) adopting the examination report as filed with modifications or corrections and, if the examination report reveals that the pharmacy benefit manager is operating in violation of this section or any regulation or prior order of the commissioner, the commissioner may order the pharmacy benefit manager to take any action the commissioner considered necessary and appropriate to cure such violation;

(ii) rejecting the examination report with directions to examiners to reopen the examination for the purposes of obtaining additional data, documentation or information and re-filing pursuant to the above provisions; or

(iii) calling for an investigatory hearing with no less than 20 days' notice to the pharmacy benefit manager for purposes of obtaining additional documentation, data, information and testimony.

(e) Notwithstanding any general or special law to the contrary, including clause 26 of section 7 of chapter 4 and chapter 66, the records of any such audit, examination or other

inspection and the information contained in the records, reports or books of any pharmacy benefit manager examined pursuant to this section shall be confidential and open only to the inspection of the commissioner, or the examiners and assistants. Access to such confidential material may be granted by the commissioner to law enforcement officials of the commonwealth or any other state or agency of the federal government at any time, so long as the agency or office receiving the information agrees in writing to keep such material confidential. Nothing herein shall be construed to prohibit the required production of such records, and information contained in the reports of such company or organization before any court of the commonwealth or any master or auditor appointed by any such court, in any criminal or civil proceeding, affecting such pharmacy benefit manager, its officers, partners, directors or employees. The final report of any such audit, examination or any other inspection by or on behalf of the division of insurance shall be a public record.

Section 13.

A pharmacy benefit manager shall be required to submit to periodic audits by a licensed carrier if the pharmacy benefit manager has entered into a contract with the carrier to provide pharmacy benefits to the carrier or its members. The commissioner shall direct or provide specifications for such audits

Section 14.

(a) A contract between a pharmacy benefit manager and a participating pharmacy or pharmacist or contracting agent shall not include any provision that prohibits, restricts, or limits a pharmacist or contracting agent or pharmacy’s right to provide an insured with information on the amount of the insured's cost share for such insured's prescription drug and the clinical

efficacy of a more affordable alternative drug if one is available. Neither a pharmacy nor a pharmacist shall be penalized by a pharmacy benefit manager for disclosing such information to an insured or for selling to an insured a more affordable alternative if one is available.

(b) A pharmacy benefit manager shall not charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including, without limitation, a fee for: (i) the receipt and processing of a pharmacy claim; (ii) the development or management of claims processing services in a pharmacy benefit manager network; or (iii) participation in a pharmacy benefit manager network, unless such fee is set out in a contract between the pharmacy benefit manager and the pharmacist or contracting agent or pharmacy.

(c) A contract between a pharmacy benefit manager and a participating pharmacy or pharmacist or contracting agent shall not include any provision that prohibits, restricts, or limits disclosure of information to the division deemed necessary by the division to ensure a pharmacy benefit manager's compliance with the requirements under this section or section 21C of chapter 94C.

SECTION 62. Notwithstanding any general or special law to the contrary, the health policy commission, in consultation with the center for health information and analysis, the executive office of health and human services and the division of insurance, shall produce interim and final reports on the use of insulin in the commonwealth and the effects of capping copayments and eliminating deductible and co-insurance requirements for insulin for individuals with diabetes on health care access and system cost.

The interim and final report shall include, but not be limited to: (i) rates of insulin utilization; (ii) an analysis of the use of insulin, broken down by patient demographics,

geographic region and insulin delivery device; (iii) annual plan costs and member premiums; (iv) the average price of insulin; (v) the average insulin price net of rebates or discounts received by or accrued directly or indirectly by health insurance carriers; (vi) average and total out-of-pocket expenditures on insulin delivery devices and glucose monitoring tests that are not included as part of an insulin prescription; (vii) an analysis of the impact of capping co-payments and eliminating deductible and co-insurance requirements for insulin on patient access to and cost of care by patient demographics and geographic region; (viii) additional funding sources for the Prescription Drug Cost Assistance Trust Fund established in section 2RRRRR of chapter 29 of the General Laws; and (ix) any barriers to accessing insulin for individuals with diabetes and policy recommendations for resolving such barriers. The interim report, including any recommendations for expanding access to insulin for individuals with diabetes, shall be filed with the clerks of the house of representatives and senate, the joint committee on public health, the joint committee on health care financing and the house and senate committees on ways and means not later than 18 months after the effective date of this act. The final report, including any recommendations for expanding access to insulin for individuals with diabetes, shall be filed with the clerks of the house of representatives and senate, the joint committee on public health, the joint committee on health care financing and the house and senate committees on ways and means not later than 3 years after the effective date of this act.

SECTION 63. (a) Notwithstanding any general or special law to the contrary, the commonwealth health insurance connector authority, in consultation with the division of insurance, shall report on the impact of pharmaceutical pricing on health care costs and outcomes for ConnectorCare and non-group and small group plans offered through the connector and its members.

The report shall include, but not be limited to: (i) information on the differential between medication list price and price net of rebates for plans offered and the impact of those differentials on member premiums; (ii) the relationship between medication list price and member cost-sharing requirements; (iii) the impact of medication price changes over time on premium and out-of-pocket costs in plans authorized under section 3 of chapter 176J of the General Laws offered through the commonwealth health insurance connector authority; (iv) trends in changes in medication list price and price net of rebates by health plan; (v) an analysis of the impact of member out-of-pocket costs on medication utilization and member experience; and (vi) an analysis of the impact of medication list price and price net of rebates on member formulary access to medications. Data collected under this subsection shall be protected as confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66 of the General Laws.

The report shall be submitted to the joint committee on health care financing and the house and senate committees on ways and means not later than July 1, 2025.

(b) In fiscal year 2024, the amount required to be paid pursuant to the last paragraph of section 6 of chapter 6D of the General Laws shall be increased by $500,000; provided, however, that said $500,000 shall be provided to the commonwealth health insurance connector authority not later than October 14, 2023 for data collection and analysis costs associated with the report required by this section.

SECTION 64. Notwithstanding any general or special law to the contrary, there shall be a special commission to examine the feasibility of: (i) establishing a system for the bulk purchasing and distribution of pharmaceutical products with a significant public health benefit

and the potential for significant health care cost savings for consumers through overall increased purchase capacity; and (ii) making bulk purchase pricing information available to purchasers in other states.

The commission shall consist of: the commissioner of public health or a designee, who shall serve as chair; the executive director of the group insurance commission or a designee; the chief of pharmacy of the state office for pharmacy services; the MassHealth director of pharmacy; the secretary of technology services and security; and 9 members to be appointed by the commissioner of public health, 2 of whom shall be health care economists, 1 of whom shall be an expert in health law and policy innovation, 1 of whom shall be an academic with relevant expertise in the field, 1 of whom shall be a representative from a community health center, 1 of whom shall be the chief executive officer of a hospital licensed in the commonwealth, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross Blue Shield of Massachusetts, Inc. and 1 of whom shall be a member of the public with experience with health care and consumer protection.

The commission shall hold not less than 3 public hearings in different geographic areas of the commonwealth, accept input from the public and solicit expert testimony from individuals representing health insurance carriers, pharmaceutical companies, independent and chain pharmacies, hospitals, municipalities, health care practitioners, health care technology professionals, community health centers, substance abuse disorder providers, public health educational institutions and other experts identified by the commission.

The commission shall consider: (i) the process by which the commonwealth could make bulk purchases of pharmaceutical products with a significant public health benefit and the

potential for significant health care cost savings to consumers; (ii) the process by which both governmental and nongovernmental entities may participate in a collaborative to purchase pharmaceutical products with a significant public health benefit and the potential for significant health care cost savings; (iii) the feasibility of developing an electronic information interchange system to exchange bulk purchase price information with partnering states; (iv) potential sources of funding available to implement bulk purchases; (v) potential cost savings of bulk purchases to the commonwealth or other participating nongovernmental entities; (vi) the feasibility of partnering with the federal government and or other states in the New England region; and (vii) any other factors that the commission deems relevant.

The commission shall file a report of its analysis, along with any recommended legislation, if any, to the clerks of the senate and house of representatives, the house and senate committees on ways and means, the joint committee on health care financing, the joint committee on public health, the joint committee on elder affairs and the joint committee on mental health, substance abuse and recovery not later than September 1, 2024.

SECTION 65. (a) As used in this section, the following words shall have the following meanings, unless the context clearly requires otherwise:

"Chain pharmacist", a pharmacist employed by a retail drug organization operating not less than 10 retail drug stores within the commonwealth under section 39 of chapter 112 of the General Laws.

"Independent pharmacist", a pharmacist actively engaged in the business of retail pharmacy and employed in an organization of not more than 9 registered retail drugstores in the

commonwealth under said section 39 of said chapter 112 that employs not more than a total of 20 full-time pharmacists.

(b) There shall be a task force to: (i) review the drug supply chain including, but not limited to: (A) plan and pharmacy benefit manager reimbursements to pharmacies; (B) wholesaler or pharmacy service administrative organization prices to pharmacies; and (C) drug manufacturer prices to pharmacies; (ii) review ways to recognize the unique challenges of small and independent pharmacies; (iii) identify methods to increase pricing transparency throughout the supply chain; (iv) make recommendations on the use of multiple maximum allowable costs lists and their frequency of use for mail order products; (v) review the utilization of maximum allowable costs lists or similar reimbursement structures established by a pharmacy benefit manager or payer; (vi) review the availability of drugs to independent and chain pharmacies on the maximum allowable cost list or any similar reimbursement structures established by a pharmacy benefit manager or payer; (vii) review the pharmacy acquisition cost from national or regional wholesalers that serve pharmacies compared to the reimbursement amount provided through a maximum allowable cost list or any similar reimbursement structures established by a pharmacy benefit manager or payer and the conditions under which an adjustment to a reimbursement is appropriate; (viii) review the timing of pharmacy purchases of products and the relative risk of list price changes related to the timing of dispensing the products; (ix) assess ways to increase transparency for chain and independent pharmacists to understand the methodology used by a pharmacy benefit manager or payer to develop a maximum allowable cost list or any similar reimbursement structure established by the pharmacy benefit manager or payer; (x) assess the prevalence and appropriateness of pharmacy benefit managers requiring, or using financial incentives or penalties to incentivize, customer use of pharmacies with whom the

pharmacy benefit manager has an ownership or financial interest; (xi) examine the impact of the merger or consolidation of pharmacy benefit managers and health carrier clients on drug costs; (xii) review current appeals processes for a chain or independent pharmacist to request an adjustment on a reimbursement subject to a maximum allowable cost list or any similar reimbursement structure established by a pharmacy benefit manager or payer; and (xiii) evaluate the effect of differences between pharmacy benefit manager payments to pharmacies and charges made to health carrier clients on drug price.

(c) The task force shall consist of: the commissioner of insurance or a designee, who shall serve as chair; and 6 members to be appointed by the commissioner, 2 of whom shall be independent pharmacists employed in the independent pharmacy setting or representatives of independent pharmacies, 2 of whom shall be chain pharmacists employed in the chain pharmacy setting or representatives of chain pharmacies and 2 of whom shall be representatives of a pharmacy benefit managers or payers who manage their own pharmacy benefit services. If more than 1 independent pharmacist is appointed, each appointee shall represent a distinct practice setting. If more than 1 chain pharmacist is appointed, each appointee shall represent a distinct practice setting. A pharmacy benefit manager or payer appointed to the task force shall not be co-owned or have any ownership relationship with any other payer, pharmacy benefit manager or chain pharmacist also appointed to the task force.

(d) The commissioner shall file the task force’s findings with the clerks of the house of representatives and the senate, the joint committee on health care financing and the house and senate committees on ways and means not later than December 1, 2024.

SECTION 66. The health policy commission shall consult with relevant stakeholders, including, but not limited to, consumers, consumer advocacy organizations, organizations representing people with disabilities and chronic health conditions, providers, provider organizations, payers, pharmaceutical manufacturers, pharmacy benefit managers and health care economists and other academics, to assist in the development and periodic review of regulations to implement section 20 of chapter 6D of the General Laws, including, but not limited to: (i) establishing the criteria and processes for identifying the proposed value of an eligible drug as defined in said section 20 of said chapter 6D; and (ii) determining the appropriate price increase for a public health essential drug as described within the definition of eligible drug in said section 20 of said chapter 6D.

The commission shall hold its first public outreach not more than 45 days after the effective date of this act and shall, to the extent possible, ensure fair representation and input from a diverse array of stakeholders.

SECTION 67. Notwithstanding subsection (b) of section 15A of chapter 6D of the General Laws, for the purposes of providing early notice under said section 15A of said chapter 6D, the health policy commission shall determine a significant price increase for a generic drug to be defined as a generic drug priced at $100 or more per wholesale acquisition cost unit that increases in cost by 100 per cent or more during any 12-month period.

SECTION 68. Section 67 is hereby repealed.

SECTION 69. The drug access program, established in section 16DD of chapter 6A of the General Laws, shall take effect not later than 1 year after the effective date of this act.

SECTION 70. To implement chapter 63E of the General Laws, as inserted by section 44, the commissioner of revenue shall promulgate regulations or other guidance regarding the reporting and payment of the penalty as soon as practicable after the effective date of this act.

SECTION 71. Chapter 63E of the General Laws, as inserted by section 44, shall apply to sales commencing on or after the effective date of this act.

SECTION 72. Sections 22 and 40 shall take effect on July 1, 2024.

SECTION 73. Sections 42, 47, 49, 52, 54 and 56 shall take effect January 1, 2024.

SECTION 74. Section 59 shall take effect on July 1, 2024.

SECTION 75. The commissioner of insurance shall promulgate regulations to implement chapter 176X of the General Laws, as inserted by section 61, not later than 1 year after the effective date of this act.

SECTION 76. Section 68 shall take effect on January 1, 2025.